ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:09:14

(On record)

CHAIR HURLBURT: .....for our Health Care Commission meeting. We'll start out with our introductions, as we normally do, and Commission members will introduce themselves and say who you represent and then we'll ask the folks that are here in the audience to do that.

Allen Hippler's going to be a little late this morning, about 11:00, I think, he'll be here, and David Morgan, who planned to be here, has a conflict with his new job where they have a board meeting and I guess he has to present the finances to the Bristol Bay Board, if he wanted to keep his job, so -- so David, who has been so conscientious and I don't think has ever missed before, David's not going to be here.

Now, we do want to have a chance to meet everybody. We have one new member here, Susan Yeager, who's being our hostess here on the VA, and this afternoon, there will be a tour, as you know, of both this facility and the JBER Hospital. We'll probably break up into a couple of groups and that will need to be limited to the members of the Commission and a couple of folks from the Governor's Office will be here with us, but that will not be for everybody else to take the tour, but I think you will find that interesting, this -- we'll hear more about those federal programs today and learn

about that and seeing the facilities.

They're both new. This is the newer one, but the JBER Hospital is new and a nice facility and so I think you'll enjoy that, for those of you who have not had a chance to see those before.

So Susan Yeager and I have been colleagues going way back, for a long time, but then, didn't have contact for quite a while until recently and Susan directs the VA program here. As you know, one of the seats, and this was at the Representative Mike Hawker's initiative, when the Health Care Commission was identified, one of the seats was identified for a person representing the program of healthcare for veterans in the state. They make such a big component of our state's population and so we've had the two past, two previous JBER commanders on there doing that and then those folks, of course, change every couple of years and they've been very helpful as members of the Commission, but we were just delighted that Susan was willing to take that seat on and that the Governor appointed her to that. So maybe if you could introduce yourself a little more, Susan? We'll start with you and then go around the table.

COMMISSIONER YEAGER: Okay, well, first of all, I'm very glad that -- and grateful to be on the Commission and so I've been -- my whole career, pretty much 34 years, of federal government, so far has been federal government. So I'm really

looking forward to learning a lot about how -- what the other sectors of healthcare -- and then hopefully contribute how what we're doing on the federal side will kind of mesh in, because what we always say, even on the federal side, "These folks are also residents of Alaska and so there's a lot of crossover and dual, and even triple eligibilities for healthcare," and so I'm very grateful to be here and glad you're able to be here at our facility and it's four years old and you'll hear more later on the tour and we have a little fact sheet and that -- about it and we'll show you some of our tele-primary care we're really getting into here and other tele-medicine-type modalities for overcoming, you know, barriers to care.

Also, this afternoon, Colonel Bisnett, she's a pulmonologist, she's the Commander of 673rd. She'll be here with me this afternoon in order to do kind of a joint presentation of what we do and then do the tours and so she's a wonderful partner. Certainly, we miss Colonel Harrell. He was awesome and we actually started a joint cardiology program when he was here, you know, being a cardiologist. So I'm looking to see, we'll probably do more in the pulmonology area, but you'll find out later.

We, the VA, actually have the joint venture and we actually staff and run, for the most part, run the ICU over there and have our other staff, 58 staff over there, but we'll

go more into that later, so I'm very grateful to be here and look forward to learning more and talking about the VA and as you -- as questions might come up in presenting, and as you know, I'm sure there's a tremendous amount of changes going on in the VA, expect to see, really, some big changes next year. So we're not even sure how our budgets are going to work or anything right now, but we'll see and we'll still move on because we still have veterans to serve and that's our mission, however we do it, so -- so thank you.

CHAIR HURLBURT: Thank you, and welcome, Susan. Bob.

COMMISSIONER URATA: I'm Bob Urata from Juneau, Alaska. I'm a family physician representing primary care.

COMMISSIONER CAMPBELL: Keith Campbell, I reside in Seward, and I'm the public representation on the Commission.

COMMISSIONER ENNIS: Emily Ennis, I live in Fairbanks. I'm a representative for the Alaska Mental Health Trust Authority.

MR. PUCKETT: Good morning, Jim Puckett. I represent the Office of the Governor and welcome to the Commission, Susan.

REPRESENTATIVE KELLER: Excuse me, I'm Wes Keller. I'm a state Representative liaison, sort of, to the House, and I guess Senator Coghill's stuck in Fairbanks and won't be here today. I just, if I could, just take an opportunity, I want to make sure that, you know, I brought a book for everybody and I didn't put it on your desk because Deb and Ward didn't

know anything about it. I didn't want to imply that it was coming from them, but it's the -- it's from RACADA Center and George Mason University and it's on the economics of Medicaid. It's a book that -- it -- if I would have had it, I would have appreciated it a long time ago, you know, it's really helpful, but the main reason I brought it, is Chapter Eight, where he talks about reform ideas for Medicaid and I think -- it inspired me, so I would, you know, I -- please take one. Thanks.

COMMISSIONER STINSON: Larry Stinson, physician and veteran, representing Alaska healthcare providers.

CHAIR HURLBURT: Senator Coghill, are you able to hear us okay, and you can go ahead and introduce yourself, please.

SENATOR COGHILL: Good morning. Good morning, Senator Coghill, duties that (indiscernible - interference with speaker-phone) kept me here in Fairbanks, so -- and I'm really disappointed that I'm not going to be able to be there at the VA clinic and go through the visit. So I'll stay tuned. Thank you for letting me chime in. It looks like I'm okay on the internet. I've got the slide up, so thank you and good morning to you.

CHAIR HURLBURT: Thank you, Senator Coghill. We heard you loud and clear and we appreciate you joining us.

MS. ERICKSON: Can I just -- real quick?

CHAIR HURLBURT: Yes.

MS. ERICKSON: Senator Coghill, I also just emailed to you the PowerPoint discussion guide to you and Reneva (sp). So if we're going too fast and you have another way to look at those or if somebody in your office could print them out for you, it might be a little easier for you to follow along.

CHAIR HURLBURT: Okay. Well, Deb, you want to go ahead and introduce yourself?

MS. ERICKSON: Deb Erickson, Executive Director of the Commission.

CHAIR HURLBURT: And I'm Ward Hurlburt, the Chief Medical Officer, Department of Health and Social Services and the Chair of the Commission. If we could have the public folks here, Michelle, introduce yourself, say who you represent.

MS. MICHAUD: Yes, I'm Michele Michaud for the Division of Retirement and Benefits. I'm the Chief Health Official.

MS. HUDSON: I'm Laura Hudson. I'm the Senior Network Executive with Aetna.

MS. TAYLOR: I'm Julie Taylor. I'm the CEO of Alaska Regional.

MS. ROBARDS: I'm Betty Robards, Director Alaska Medicaid Behavioral Services for Qualis Health.

MR. LESSMAN: Good morning, my name is Mike Lessman. I'm a policy advisor for Governor Parnell and I work in the Juneau Office of the Governor.

MS. SAXON (sp): Good morning, I'm Pat Saxon. I work for

Alaska Native Tribal Health Consortium on state issues and I work out of Juneau.

CHAIR HURLBURT: Barb.

MS. HENDRICKS: I'm Barb Hendricks. I'm the administrative assistant for the Health Care Commission.

CHAIR HURLBURT: And Barb's the one -- for everything that works right, it's Barb's fault, and if you folks could introduce yourselves, please?

MS. STUDSTILL: I'm Miranda Studstill with Accu-Type Depositions.

MR. SAYLOR (sp): Ryan Saylor with IMIG Audio and Video.

CHAIR HURLBURT: Thank you, and again, welcome, everybody here. There will be some others joining us, I know. I want to say just a few words and set the tone. My wife and I are leaving tomorrow night and going to Florida for a week. So I already had a couple of books and now I have three, and thank you, Representative Keller, for bringing that.

It was interesting, Donna Shalala, I was telling Representative Keller, Donna Shalala, who was the Secretary of Health and Social Services during the Clinton years, is on the Board for Pediatrix, which is the for-profit corporation that has neonatologists and they have the contract, Dr. Lily Lou, who's a very able Director of the Level III NICU at Prov, works for them, for example, and they had their board meeting up here and had a reception over at Prov on Friday afternoon

for their board members and I was there and talking with Donna Shalala, the former Secretary Shalala, and her comment was, you know, "What are you going to do about Medicaid?" You know, "What's your Governor going to do about Medicaid?" You know, "How can you not take all of this free money that's just sitting there on the table," and it's kind of part of the national discussion of it's free printing press money that's not really there.

So I, knowing that it's coming from you, I think this will present a balance to that perspective to just run the printing presses farther. So thank you very much for thinking of all of us and bringing that here and I look forward to reading it, Wes.

The cost of healthcare is our major focus and it receives a lot of focus around the country. This is the current issue of "Kimplinger's" magazine and it says; "50 ways to save on healthcare," and there is a several-page article in there, mostly, fairly, simple, straight-forward stuff that most enlightened consumers would know, but it's getting a lot of attention and continues to receive a lot of attention.

There was a study that was done and just published in the last few days by the -- and it's called "Physician Beliefs and Patient Preferences: a New Look at Regional Variations in Health Care Spending," and the lead author on this is David Cutler, who is the same one who wrote a book on quality, which

is the second book that I'm taking to read on my vacation that Bob has recommended to us here in the past, and to read that -- that study, and this comes from the National Bureau of Economic Research, you need, I think, a degree in Greek, because they have all these mathematical formulas with the Greek letters in there, but it is interesting and I have read through it, but this was the -- this was from "Common Health," that was more the summary of the article and this is titled, "Cowboy Doctors Could be a Half Trillion-Dollar American Problem," and they actually do use the word cowboy in the article here and what it -- what it addresses, these are -- it's kind of like the BRFSS, the Behavior Risk Factor Survey, that we do every couple of years and so it's self-reported information and they interviewed a fairly substantial number of cardiologists and family medicine physicians.

So it's self-reported data on what they do and what they mean by cowboys, are physicians who self-report that most of the time, all of the time, say if somebody's in the end stage of life, they will do heroic things, which often prolong dying and create more suffering and so on, and add immensely to the cost, the same thing looking at family medicine physicians.

So just those two chunks there are out of our three trillion-dollar annual national healthcare economy, they said those, what they're calling cowboy types of practice, cost us a half trillion dollars a year, and we've used the numbers

before here that if we were really able to embrace and foster evidence-based decision making, we're talking a trillion dollars and David Morgan would not have had to worry about having a conflict because there would be no Health Care Commission if we were saving a trillion dollars a year on that, but that was interesting to see that, as we see more national attention.

Now, related to costs and other things, again, you've all seen and heard the news and related to hepatitis C and hepatitis C treatments, and this is a national problem. It's estimated that about 3.2 million Americans are carriers for hepatitis C. CDC recommended a year ago or more, I guess, that all boomers have hepatitis C because that was a group, and many in this room are in that age group, but it was a group that in the kind of experimenting that people have always done, since there were people, and growing up, there was some experimentation with injectable drugs and that's the highest risk factor.

It's not the only risk factor for hepatitis C, but that's why that particular group was singled out and there is that recommendation that they get treated. Now there have been treatments for hepatitis C with cure rates that sometimes were really quite competitive of cure rates for some other diseases, but a lot of complications and not the 100% cure rates that you might see for some other kinds of diseases, and

so the new drug Sovaldi, which we've mentioned before, Sofosbuvir is the generic name, made by a company called Gilead, came along and the reported cure rates are quite good.

Now, hepatitis C has six different genotypes. So this gets a little bit technical. There are four types in Americans. The most common type is Type I of -- and the -- in the -- in treating people, there's a push and there are advocacy groups, of course, that are pushing for everybody. It's causing big problems for prison systems because of the cost of treatment for hepatitis C.

Well, there was a report from the "Portland Oregon Business Journal" that said that Oregon, on their Medicaid program, is getting close to having a clear policy about who should and should not be treated and it is -- Sovaldi is the best drug that's come along, higher cure rates, lower complication rates, although, both may be more optimistically stated than the reality is, but for the Oregon Medicaid program, the entire pharmacy budget to date is $377 million a year.

If they treated all of their Medicaid-enrolled hepatitis C positive patients, they would add -- they would increase their pharmacy budget by $480 million, just from treating the hepatitis C patients. So the currently 377 million, it would be an additional 480 million on top of that.

So then there's what's called the Med Project, which is

an evidence-based medicine analytic group that about 15 states or so, including Alaska, participate with. Jim and Michele would be quite familiar with that and they have done some very credible work looking at it. For the genotype I, which is the most common in Americans of hepatitis C, they are being treated with a combination of the Sovaldi, which is the one that's $1,000 a pill, a pill a day for 12 weeks, $84,000 just for the medication, and Olysio, which is made by Janssen, which is a subsidiary corporation of Johnson and Johnson, so one of the big top three pharmaceutical companies, ethical company there, and that's almost as expensive, so about $150,000 to treat them there.

That protocol for treating for 12 weeks, individuals with the genotype I hepatitis C, at a cost of $150,000 is based on one unpublished study that has never been submitted to peer review with a total, for that particular protocol, a total of 28 patients, and the -- if all the 3.2 million were treated, that's about $300 billion a year for the U.S.

So I was in another meeting yesterday where a provider entity was being quite happy, because they're being able to treat and I think, they do have some good guidance on picking individuals. If you have an individual who has fibrosis of the liver, maybe early cirrhosis, and they're going to need, in the next couple of years, possibly a liver transplant, so then you're talking half a million bucks or more, they are

serious candidates for having this drug now, but for everybody with hepatitis C, the drug -- the disease does not progress that rapidly.

It's interesting that Gilead, who has been so humanistic in developing this wonderful drug and charges us $84,000, is sending that same 84 days of treatment, the same 84 pills to both Egypt and Indian at $900, instead of $84,000, and on that, from the information I have on their manufacturing costs, their profit margin is only about 400% on the $900.

So that's continuing to receive a lot of attention. I've got a policy from one very well-known, very reputable and successful large, major health insurer here and while they -- they are being somewhat selective in whom they are treating where they are at risk for the cost, they're treating many individuals according to the protocol that I just described, based on the 28 patients. So we're seeing nationally, lots and lots of money there.

So that's another part of the background and the need for evidence-based medicine, and just one final brief thing, we talk about prevention. We talk about that probably less than other things because we may not be in the position to foster that, but we know that, so much now, we die of diseases of choice, where it used to be accidents, injuries, you know, especially infectious disease and while hepatitis C, while ebola, which we read about and the tragedy there in West

Africa now, that infectious disease, that contrary to what was thought maybe a few decades ago, that we are certainly not beyond the days of infectious disease, but we do, as Americans, especially, die of diseases of choice and diabetes, related to overweight and obesity, which the Division of Public Health for five plus years now has said it's our number one public health problem, that the CDC had projected back about 10, 12 years ago, that 38% of girl babies, 34% of boy babies in the U.S. were at risk of diabetes as adults because of our increase in overweight and obesity.

They have revised that projection. Now 40% are projected as being at risk of diabetes as adults and some subgroups, like 50% of all Hispanics and 50% of black African American women, are at risk for the diabetes, with shortened lifespan, with blindness, with kidney failure, with need for kidney transplant, with loss of limbs, from diabetic ulcers on your feet, and with immense cost to us.

So again, it's a reminder, and we're seeing some successes in Alaska. We have the Healthy Futures program that's a private/public partnership on that. We now have 20% of the elementary school kids statewide participating in that three-month venture, fall and spring, committing to 30 minutes of physical activity, preferably with their parents, three days a week outside the school setting. It's not a lot, but it's up over the last three or four years from having about

1,400 kids, I think it was, up to now, over 15,000, about 20% of the kids in the state.

We -- I think you've mentioned before that it's statistically significant, although small, it could be a blip, but we hope it's a trend. Anchorage and Mat-Su school districts have seen the rate of overweight and obesity in their school kids go down a little bit. Those school districts supported it. The superintendents got behind it, improved school lunch and breakfast menus, restored more physical education, more activity, recess times.

It's a couple of percent drop. We've gotten some national attention for it, so some good news, but this reminds us, just a huge dark cloud over our head there, that for the most part, is preventable, and so we need to keep that as a part of our background. So let me -- that's kind of the tone setting for today here and then we'll go ahead and move on.

Deb is going to Chair the next couple of sessions. The first one will be on the status of the Commission, kind of a combination of where we've been and where are we going, and then a little update on the fraud and abuses, so Deb.

MS. ERICKSON: Yeah (affirmative), and actually, the discussion around fraud and abuse will be a little bit more of a work session. First, I just wanted to start with a little bit of a review of what -- or at least point out a few things that are in your notebook, since you didn't receive it in

advance this time, and I wanted to make sure that you knew about some of the contents here.

First of all, with our two new members, plus a couple of job status changes of our existing members, and then the recent loss of Val from our Tribal Health seat and Jeff from the health insurance seat, we updated the members' bios on the web and I provided a copy for you of the current roster and biographies that we have for everybody. We have Susan's and Becky's included here now.

So that's behind your agenda in Tab One and Barb also updated for us, the contact list, the contact information for all of the Commission members and that's immediately behind the updated bios there in Tab One. Then just as we normally do, just for reference, at any point, if you need to or want to, look at our authorizing statute and our meeting ground rules. Those are behind Tab One as well.

There are a lot of different documents behind Tab Two. It's all about our discussion today related to process for the most part.....

UNIDENTIFIED SPEAKER: (Indiscernible - intercom speaker).

MS. ERICKSON: It's the -- sorry about that. So I'm not used to that. Then for those of you on the phone, we're just hearing some of the intercom system for the health clinic here. So I didn't know if that was somebody on the phone.

We'll adapt to that and so I'm not going to go over, but I'm going to refer periodically to some of these documents and we might have to stop and I'll help you, since they're so many different documents behind Tab Two right now, but I'll be referring to those over the next hour or so and possibly tomorrow.

So what I wanted to spend a little time with now -- with you all now is talking a little bit about our process and our progress and I will confess, but I'll take full responsibility for our last meeting of I felt a little bit frustrated with where we were at with the process and -- but it's all good. Dr. Hurlburt kept telling me, "This was a great norming conversation that we had with this group," as I would come down and fume in his office periodically.

So I just wanted to reflect back a little bit on my perception of those two meetings, where we're at, and then talk a little bit about where we're at with the process and how we're going to regroup around process moving forward, because this year, really, is a transition year and we were scheduled to sunset at the end of June and if the Legislature hadn't introduced and passed a bill to extend the Commission for three more years, our June meeting would have been our last meeting and Barb and I would have been spending this next year, and just so you understand the process, the -- when a state body in our state sunsets, there's a provision in state

law that has the body continue just for administrative close out for another 12 months after the sunset date.

So this group would have gone away. Barb and I would have spent this next 12 months working on tying up kind of administrative loose ends and also -- I just want to make sure our PowerPoint is working, and the main thing that I would have been doing at this point to kind of close out our process and provide a final product from the Commission, and I just want to remind you about this, I'm going to refer to it a couple of times for a couple of different reasons over the course of our meeting, and Susan wouldn't know about this, I don't know if the rest of you remember, but there were a couple of times I brought this before you last year, and I've included as an appendix in our report, a framework that we put together for developing, working with state agencies to develop an implementation plan for implementing the recommendations of the Commission, and Dr. Hurlburt and I spent some time meeting with some of the key state agency leaders, would have the main responsibilities, so -- for implementation activities, so the Department of Administration, folks in Jim's shop responsible for the employee and retiree health plans, the state Medicaid Director, Margaret Brodie, just as a couple of examples, and documenting and starting to tease out what some of those action steps would be, and so we have a draft of this document

and our whole focus, I think, over the -- for the wrap-up would have been finalizing this document.

This is something that it won't -- I don't know that it would technically be a product of the Commission, as much as a product of the Commissioners for those state agencies under the leadership of the Department of Health and Social Services and our authorizing statute actually included in addition to the section that creates the Commission, it made a change to the Department of Health and Social Services' responsibilities to include development of a statewide health plan for implementing the recommendations of the Commission.

So essentially, the Commissioner of the Department of Health and Social Services is charged with developing this implementation plan and leading that process and Commissioner Streur, because of -- particularly because of the additional work right now with the transition with the new Medicaid management information system that's causing so much trouble and also the focus on the Medicaid reform advisory group, has asked us to kind of step back a little bit on that process and focus on completing it during our next calendar year, during 2015.

So I just wanted to let you know that that hasn't gone away and it's kind of an important component of the Commission's kind of next phase of work, but again, I'm going to go back again and reflect on those two meetings.

We had just started talking in March, we didn't know if we were going to be continued or not, but we spent part of that meeting talking about what our future role should be, assuming that we were going to continue and to help with me with planning our meetings for the rest of this calendar year, if that was going to happen, and we talked about how the Commission could, with a fairly complete set of strategies and recommendations at this point, and with the increasing interest from legislators and others and working on implementing those, that we could move into a convening and facilitating phase working with our existing policy recommendations.

We talked about doing -- focusing on transparency and potentially hosting a stakeholder session in the fall on transparency as a first step and completing the All-Payer Claims Database legislative elements policy paper that had -- that I had drafted in response to legislators' questions.

So we talked about that and I thought I had a charge from you all that we would work on that going forward and start planning those things, and so when we had the conversation at our June meeting around transparency and I wanted to try, as an experiment, just having a more open conversation like we'd had in some of our earlier Commission meetings, the outcome of that meeting was, no, we're not going to work on transparency this year.

So I wanted to -- I included -- I made a point of documenting that in our meeting notes and you did all receive those meeting notes a month or so ago. They're posted on our web and they're included in the notebook. Dr. Hurlburt tried to get us to vote, at one point, to formalize the process a little bit and I felt as though the message was clear enough that we didn't actually need a vote. We try not to use Robert's Rules and formal voting processes, except when we're making decisions about our official finding and recommendation statements.

It was really -- actually, it was very helpful for me, because I think I really was jumping an important step in trying to take this group from one role to another without stepping back and thinking about what our process should be. I was leaving the process behind and jumping right into a new role, which was not helpful at all, I don't think.

So I've done a few things since that meeting that I want to share with and then prep you for our October meeting, where we're going to really spend some time in a decision-making work session for a good half a day and I want you to start thinking about that and preparing for it now.

One of the things I did, was I have hired a consultant who's going to facilitate that work session in October and I've put -- started taking some of our existing recommendations and putting them into -- I was feeling a need

to try to diagram those and provide pictures of those, but first, I want to talk a little bit about our process.

This is as much for Susan, as a reminder for everybody else, just very quickly -- I'm actually going to spend a little more time talking about this in October, but just revisiting, at a real general level, what our process has been over these past three years, I guess -- go back and think about 2011.

We were established in law in 2010, but it was pretty late in the year before the Governor signed the bill and appointed the new members. So in 2010, we were just getting started at the end of that year. So 2011 through 2013 were the three years that we were really operating and produced a product that, apparently, the Legislature appreciated enough that they wanted to continue us for another three years, so -- and then our sunset date will be in 2017.

So thinking about 2011 through 2013 as a first phase, those three years, 2014 now, the calendar year we're in now, as a transition year, and 2015 through 2017, those next three years, is kind of a phase two for the group's work. I don't know how we might adapt this process, but in those first three years, this is the process we were following, really a traditional kind of plan, study, do, act, where we spent some time -- we started off with a vision for the future and our vision being that by 2025, Alaskans will be the healthiest

people in the nation and have access to the highest quality, most affordable health care.

So we've developed the vision, but then we've spent some time each year studying current conditions of the system, so we understand better where we are now and in -- to help inform the path we need to take to achieve the vision in the future and we've also spent time, then, studying strategies for reform for transforming the healthcare system in our state in order to achieve the vision that we've identified.

So each year, we've spent some time studying potential strategies for transformation and improvement, sometimes studying current conditions of the system. We don't develop recommendations around those studies of the current condition, but we identify findings and recommendations, then, related to the strategies that we've considered.

Then we have, also, a high level set of metrics and check in periodically on whether and how our recommendations are being implemented and how we're achieving our vision and I've listed in our study guide, the major studies that we've accomplished in the studying current conditions phase and then, of course, our kind of eight-course strategies and the body of recommendations we've developed around those.

So that's just -- and especially for Susan, kind of a general overview of what our process has been in our role and our role has really been as a study and advisory group, and

remind people periodically and have to explain to new folks finding our Commission and trying to understand what we're about, is that this group isn't a collaborative. It's not a coalition. We're really just advisory on policy issues, state policy issues to the Governor and the Legislature and we're trying to be as independent and objective as possible in understanding the issues and trying to describe the issues and coming up with some recommendations.

So that's what our role has been, and you'll have to excuse me, I'm a little bit challenged. Normally, I have my own laptop and I'm able to see that and not turn my back on you all while I'm going through the presentation, but I might have to stop and turn around periodically to make sure we're where I think we are on the screen.

So okay -- so just thinking about, since we were extended, and that it will be important for us to spend a little more time together thinking about and talking about what our past processes and our rules have been and also talking about and understanding what the Legislature's endorsement of our work so far means, and what the implications are, what the Legislature's and the Governor's expectations for our next three years are, and then have that kind of set the stage for what this new phase and what a new role might include.

So I'll move on from that, and I'll stop for a second to

explain why I was feeling as though we needed to stop and figure out how to diagram. We have the summary document. I'll pull it out, so I can reference it. The -- we prepared it a couple of years ago and I've updated it as we've added strategies and recommendations, but our core strategies document that you all have, and there are copies out on a handout table, too, but it's behind Tab Two, and so this is a 14-page narrative that includes all of the official recommendation statements of the Commission made to date and with the first two pages just being kind of a summary, a two-page summary, that describes in more general terms what the core strategies that we've organized our policy recommendations around and the expected outcomes, anticipated outcomes, from implementation of those policy recommendations.

It's been a helpful summary, I think, and feedback has been positive about it, because otherwise, all of those recommendations and the work we've done are buried in our annual reports, but in part or primarily, because of some of the swirling we were doing in conversation at our June meeting around transparency, in general, but particularly around the All-Payer Claims Database, I felt as though we were forgetting, which is easy to do, the three years' of study we had done on an All-Payer Claims Database and some of the -- some of the things we had learned about it.

The group was particularly focused and concerned about

one particular use for an All-Payer Claims Database, which is consumers' use of information, and Susan, do you know what an All-Payer Claims Database is? Maybe we'll take a minute to explain that.

An All-Payer Claims Database is a database of paid claims data from all public and private insurers in a state and there now are 11 states that have operational All-Payer Claims Databases. One -- a key component that we learned in that is an accompanying state law that would require private insurers and direct public insurers, state public insurers, and an invitation to federal public insurers to participate in submitting their paid claims data to the central database.

So there are 11 states with mandated operational All-Payer Claims Databases. Now, there are another six that will be coming online in the next few months to a year or two. There are an additional three states that have voluntary ones now and there's significant interest, it seems, nationally in creating these databases to -- for a number of -- for a variety of purposes, and so since we were so stuck on that one issue of, could we use this data effectively to inform patients and referring clinicians about prices and the amount that they would expect to pay and also bring some quality information, to the extent we could pull some quality information from the administrative claims data, into a public facing website that then consumers would actually access, and

we spent a lot of time talking about that and we didn't step back at any point and I didn't help the group to step back and think about some of these other reasons that we have identified and potentially uses of it.

So I was trying to think of a simple way to diagram that. So that's what got us started and that's what this diagram is meant to do here. It's probably not perfect, but it shows how one of the things that we -- we had identified that the All-Payer Claims Database would support numerous strategies, not just the transparency strategy, and just as one example, so that's what this diagram is and you have it in your slides in the discussion guide and also it was a separate handout.

So you can maybe see it a little easier than you can see it on this screen, and I don't want to go over it in detail right now, I just wanted to show you that that's kind of what got me started after this last meeting, thinking about is there some way we could diagram these policy recommendations just as a reminder and to make it easier to get a quick snapshot about, you know, some of the key elements and purposes and reasons behind our various policy recommendations that we've made so far.

So I'll skip ahead and then go back to that other one. So that evolved into this -- an idea that I wanted to put together, if possible, just a single page diagram to try to capture our core strategies and our policy recommendations in

more kind of a graphic form and so this is my first attempt at doing this.

One of the challenges is trying to take 14 pages of narrative and be, you know, real faithful and honest and fair in how I'm capturing those in just a few short, short, short bullets that I could stick into little boxes. So again, you have this behind Tab Two. It's in the discussion guide, this diagram, and it's also a separate handout there and you're going to have an assignment associated with it between now and the October meeting. So I want to -- I'll tell you about that in a minute.

Essentially what this is, is referred to, and I don't know that I've been completely faithful to the strategic map, but I've used this type of a diagram years ago in the past for working with an organization's strategic planning process and to show a picture of the strategic plan and at the top, in the very top bubble that's orange, is the central challenge that these strategies are meant to address.

So what I did, was I took our vision statement and rephrased it just slightly to describe it, not as a vision, but as a central challenge, and so the way that reads now is that the central challenge is to transform Alaska's healthcare system so that by 2025, and our -- Alaskans will be the healthiest people in the nation and access to the highest quality, most affordable, healthcare, and then what I've done

is taken our eight core strategies and put those into strategy boxes and I took three that I had thought were a little more cross-cutting, that support the other strategies and some elements should be -- some elements and some aspects should be addressed in more than one of the -- some of the core strategies.

So I took three of our eight and identified those are cross-cutting strategies and those are the three purple bars at the bottom and then for each of the core strategies, those five core strategies that are a little more siloed in this diagram, I've -- the box is hanging off there, describe very briefly, again, the policy recommendations that we've made to date and some of those, I've lumped together for -- in different ways for different reasons.

If it seemed as though the type of work to implement it was really related or kind of there was a theme, I need to pull this out so I can see it in the dark without having to keep -- to turn around on you. So if you -- if you have it in front of you, if you can't see the words on the screen, it might be helpful, as I point out just a couple of examples.

So for example, if you look at the far right, Core Strategy Six, Improve Care for Seriously and Terminally Ill, I've lumped together the first three areas of recommendations into just a simple, educate the public and clinicians, and just you can refer to this other document if you want to see

the full body of the recommendations, but that first recommendation is all about increasing educational opportunities for the public and information and resources for the general public to understand the importance of planning and to understand the issues better and there are also a couple of, then, recommendations related to continuing education for clinicians and education -- educational programs and clinical training programs.

So I've lumped those all together in just a single box and just as an example of one of the lumps that I've created here, and then the numbering system, this is maybe getting into a little too much detail, but just so it doesn't get too confusing, this core strategies and policy recommendations document, until yesterday, had a date of December 2013, and now it's August 2014.

I didn't change one word in the document, but what I did, there were some of those policy recommendations that were more kind of stand-alone that didn't have a number associated with it, it was just a bullet, I made sure that everything in this document was numbered so that you can have a -- so that you'd be able to cross reference from the strategic map to this document and see the exact language that's associated with those policy recommendations.

So for example, the box that I was just pointing to, VI, which is Core Strategy Six, Improve Care for Seriously and

Terminally Ill, the one, two, and three in that box refers to the first, second, and third policy recommendation under Core Strategy Six in this document. So does that make sense, and the reason it's important that makes sense is that one of your assignments between now and I'll probably give you a due date of the middle of September, and I'll follow up this meeting with an email, so you have -- so -- as a reminder and so you have everything handy and it's clear, one of the things I'm going to ask you to do is to go through this strategic map and identify whether you think there's any room for improvement in the way I've captured and grouped the policy recommendations and if you think that I've been -- if -- left something important out or mischaracterized it, I'm going to invite your suggestions for improving this diagram.

So I've been doing a lot of talking. One of the things, I'm just going to point out, but then I'm going to stop and see if you have any questions or responses, I just wanted to point out in parenthesis in those purple bars, since there isn't room there to capture for our cross-cutting strategies, the policy recommendations, I just kind of captured those even more briefly in parentheses on that one page, but then created a second page where I dropped the policy recommendation boxes off those cross-cutting strategies.

This is going to be a tool that we're going to use for the decision-making work session that we're going to have in

October, which is why I'm going to ask you to try to get your comments back to me by mid-September, so we can finalize it for the purpose of that exercise, but now I'll stop and see if -- invite any questions or any comments you all might have at this point. Yes, Dr. Urata.

COMMISSIONER URATA: A few things.....

MS. STUDSTILL: I'm sorry, would you turn on your mic?

COMMISSIONER URATA: Microphone. Under your focus on prevention, the purple, number seven, I'm wondering if clean air is part of that, and of course, I was involved with the Heart Association, Cancer Society, and Lung Association with, you know, a statewide clean air, because 50% of the state of Alaska is not covered by the local laws or something like that. There is some public reason for that and so clean air is important. It reduces the -- indoor clean air, or reduces risk of cancer, heart attacks.

We've seen in communities that have or states that have gone to clean air, a marked or a significant decrease in heart attacks within a year when they compare the year before and the year after. So I'm wondering if that's something that should be added to that, and then the other this is, under number three, Pay for Value, you know in that book by Cutler, I think that kind of clarifies it, but -- and this is where this comes from, is that, you know, in health care in the United States, we have poor quality, a lot of mistakes are

made in hospitals, in clinics.

We have people who don't follow evidence-based medicine or evidence-based recommendations, you know, on the provider side and in the delivery of the health care and so I'm wondering if we need a box for that, because I think that that's a focus where you can make a lot of savings.

If you have a hospital that's making a lot of errors, for whatever reasons, their processes or systems are not working well, or you look at individual physicians, you know, now some of that comes under pay for performance, you know, the value of that and so I'm wondering if there needs to be a box for that or is it already covered in, you know, pay -- under Pay for Value, but -- in one of the smaller boxes under Pay for Value? I'm not quite sure that it covers sort of what I would call mistakes, you know, reducing the mistakes in health care.

MS. ERICKSON: I think it is.....

COMMISSIONER URATA: Or have we even talked about that.

MS. ERICKSON: .....captured there. So you just raised multiple issues here.

COMMISSIONER URATA: Yeah (affirmative).

MS. ERICKSON: Let me take the first one and then work backwards, because part of -- this is going to seem like I'm going off on a tangent, but this is all related. One of the other things I was going to point out to you is the -- one of the -- the title off to the side of the top of the strategic

map, Solution Focused Approach, one of the -- because that's really what we've taken, is focusing on solutions. While we spend time identifying problems, we talk about the problems.

Our approach has been to focus on the solutions, but after the last meeting, where one of the questions that kept coming up is, well, we need to define the issues. We need to define the problem, and I kept thinking, "Well, we just spent three years defining the problem."

So I did a couple of things. One, I started working on a map of -- that looks just like this, but it's organized in a different way and it shows our policy recommendations organized around problem statements and that is the problem-focused approach, and I think it will be helpful to have that. I showed an early draft to Dr. Hurlburt and he went (indiscernible - audible sound), just because when you take a problem statement and boil it down to two or three words, it's not very nice.

So I'm working on trying to make it a little nicer, but we get enough questions and folks going to the -- the problems and we need to be reminded, I think, of the problems that we've identified and how these solutions organize this -- the recommendations we've made organized to address those different problems, and so I'm working on that, but the other thing I did, and I'll point you back to, like I warned you, I would refer you regularly to Tab Two in your notebooks, I --

I'm not going to take credit for this.

Barb worked on this for us and we had never done this before. It was to take all of our official finding statements, where those problems and -- those problems and those issues are captured in the official finding statements. In order to keep that document, our summary document, short, it's grown to 14 pages now, we've only included our recommendation statements in this summary.

This document now pulls from our annual reports, all of the finding statements and recommendation statements, that the Commission has made and approved, and it includes, you know, our preliminary year when the earlier, smaller Commission was organized under the Governor's Administrative Order. So it pulls from those 2009 -- and just so you know, Susan, when the Commission regrouped under our statutory charge, the group was expanded under the statute, because you know, nothing can go through a government committee without -- so it was a bigger group.

We had an expanded charge, but that group voted to pull forward kind of the framework that earlier group had laid out as a foundation and so we refer to that -- I mean, they had an official vote in 2010, this body did, to essentially adopt the work of the 2009 Commission. So we include it here.

So there is -- and it starts with -- there's a table of contents. All of the -- those, not five, annual reports, and

I'm not going to go over that in any detail, but just so you all, and we'll post this on the web, so the public, too, can have a reference to the findings that we identified that focus a little bit more on the problems and the issues around which then the recommendations were framed.

So in answer to your question, Dr. Urata, about whether the issue of waste and quality is captured under our Pay for Value, I think it is. It was something that we talked about a lot. It was before your time on the Commission in the learning sessions around that and I think in both the findings and the recommendation statements, if you'll go back and review those, it's defined and it would be captured under here. Yes.

COMMISSIONER URATA: Yeah (affirmative), I just think -- I'm just not sure, but I don't remember reading about mistakes and I call them -- I mean, people call it quality because it's a nicer term to use quality of care, but I think there are actually things that have gone wrong and there's a lot of it that happens in our healthcare system, but it's not talked about a whole lot and -- but it costs millions of dollars and if we could do things like doing the checklist, you know, take time out before you start surgery to make sure you have the right patient, the right left or right side, and things of that sort, then you don't have to do things over again.

If you do more "cookbook medicine," following certain

policies and procedures that are based on evidence-based guidelines, we've found that some of those things improve outcomes and improve care, instead of each individual kind of trying to remember -- each individual physician trying to remember the orders and doing it, but if you more -- follow more guidelines, or you know, sort of, we call it "cookbook medicine," then you know, that improves the quality or reduces mistakes and so that's why I use the term mistakes instead of quality, because quality is a broader term meaning a whole bunch of different things, but another thing that, you know, some of those things can be measured like what's your rate of post-op infections and so those are things that are being followed.

How many times does your patient return to the hospital for the same problem within 30 days? Medicare is measuring that and grading hospitals on that and taking money away, so that those kinds of things -- and I'm not so sure it's all reflected in the boxes. So I just wanted to point that out, because I think that's where you're going to get more bang for your buck, that -- those specific things.

MS. ERICKSON: Yeah (affirmative), medical errors, specifically, weren't something we called out when we were learning about Pay for Reform. So you're right. You wouldn't have read that, specifically, but the focus -- since the Commission is focused on making state government policy

recommendations, I believe that we would -- the intent is to address those problems in addition to the broader quality issues through policies that would drive a change in the way a payment is made, so that clinicians then could be supportive of the new payment structure to drive -- to make those improvements, rather than government directing that guidelines and checklists be developed, that they would be incentivized to do it through new payment structures.

COMMISSIONER URATA: Okay, okay.

MS. ERICKSON: One of the things that we've -- and just along those lines, because we're going to have a learning session, actually, at our next -- at our October meeting. So remember, it was one of the things we -- and Susan, for your benefit, one of the things that we do each year is identify what our agenda for the next year is going to be and we'll come up with a list of strategies we want to focus on and a list of current issues that we want to study a little bit more and understand more, and on our agenda for this calendar year is clinical quality and so one of the things we talked about at our last meeting is what exactly the group wanted to learn about that and what we should do and I left to -- that meeting to go work with Becky Hultberg and ASHNA, the State Hospital and Nursing Home Association, on putting together a learning session for you all at our October meeting and that process is going really nicely, and we're going to spend time, first with

providing you all with a framework for some of the new mandates that hospitals have right now for reporting quality through Medicare, primarily, but other payer sources that are driving some of those new requirements related to quality and how payment is being affected because of that.

So we're going to learn about that. We're going to learn about some of the things, the initiatives that hospitals are implementing now voluntarily, too, and a special request is to identify some of those initiatives that have a particular link back into the community and clinical practice that you had mentioned specifically, Dr. Urata, that -- but most -- right now, most of the government requirements and payment structure changes are focused on hospitals and so we're -- it will be more focused on that, but we will have that learning session. We're in the process of organizing it right now for our October meeting.

COMMISSIONER URATA: Thank you.

MS. ERICKSON: You're welcome. Your other question, and this gets to the bullet and things about smoking and tobacco, this map only includes our current standing policy recommendations and we do not have any recommendations right now, policy recommendations related to tobacco, so -- so no, it doesn't, and that's why. Yes, Representative Keller.

REPRESENTATIVE KELLER: First, I've got to say I really thank you and admire and respect and appreciate your

organizing this information. It really helps me. At my age, my scope, I tend to forget where we're at, you know, so you know, this really helps me out, but as I look at this, I think of a solution focus that may be, you know, ought to be included more specifically, and that is -- well, first of all, let me back up and give a little bit of background.

As I look through the strategies, you know, we put a lot of emphasis over time here in the Commission on patient responsibility in making clinical and economic decisions, and you know, the informed consumer and the purchasing, you know, power of an informed consumer and we've been talking about all these kinds of things.

This group has better capability than anybody I know to identify policies and regulations that stand in the way of innovation and even stand in the way of making good evidence-based decisions, and I'm wondering if we shouldn't spell out a solution that is specifically that, you know, that we're looking for ways to break down the barriers to be able to, you know, get some of these good ideas out there on the table.

We've looked at the tele-medicine innovation. We haven't looked at, I don't think, and correct me if I'm wrong, you know, what stands in the way of using tele-medicine more effectively. You know, it's happening, but it happens, as I see it, from my perspective, outside of the provider world, you know, it happens incrementally and by people that are real

innovative within the providers' system. So I'm just wondering if one of the boxes shouldn't be, you know, identifying and eliminating the regulation and policy that prevent the rest, so.....

MS. ERICKSON: Well, you all will need to hold that question in mind, because it's not going to be, I don't think, a matter of me defining or adding boxes to this map, but it's going to play into the question that you're going to answer and the decisions that you're going to make in October.

So we can hold onto that thought and then follow up on it when we get to process and see if folks have any other questions about this map. Why don't we do that?

REPRESENTATIVE KELLER: That's fine, and I knew that was a danger. That's why I started with complimenting you and I know it's organized in a way that makes sense, you know, and I'm (indiscernible - speaking simultaneously).....

UNIDENTIFIED SPEAKER: (Indiscernible - speaking simultaneously).

MS. ERICKSON: Yes.

COMMISSIONER URATA: I would like to compliment you, too. I'd like to echo that compliment.

MS. ERICKSON: I do not need compliments, but more a kick in the rear, so -- which is what he gave me last time. It was good. It was good. Any other questions or comments just about this, the diagram? Okay, so I'm going to -- yes, go

ahead, Susan.

COMMISSIONER YEAGER: I'll just say for me being new to this, it really helps me to see the picture. It really crystalizes and it kind of puts it in a structure. I really appreciate this because I'm kind of more of a visual kind of person, too, where I can go, "Okay, here's the connection," and then try to understand what that all means, just thinking about to me, then I'll say, this is kind of separate, for us here, it's one of our biggest challenges for the technology and interacting with our partners is the exchange of medical information, and that's why we're so pushing -- I'm pushing very hard on getting the VA involved in that (indiscernible - coughing) project, so that we can have that medical information wherever that, in our case, our veteran patient is around the state, if it's private, it's -- regardless of federal, et cetera.

REPRESENTATIVE KELLER: Yeah (affirmative), and I think as we look at that, you know, we all see that, because that's been the basis of our discussion. I was just thinking about it from the perspective of what the Legislature's looking for, you know, if we can find the, you know, unique -- as the -- the Legislature today, if you can find a regulation, we can throw it out the window, that makes more healthy people, you know, it's all -- yeah (affirmative), that's why I was looking at it that way.

MS. ERICKSON: Okay, so we'll talk a little bit about what our process is going to be and the questions that we want to answer, because I mean, the question we want to answer, I want to go back to what we discussed in March, as what our, kind of our next phase role could and should be, is to facilitate implementation of some of these recommendations where -- and we have no authority, not being a regulatory body, but we can we serve as a convener? Can we do additional studies to just, for example, to your question, Representative Keller, identify where there are barriers to integration and/or implementing any of these recommendations.

So we might, for example, looking at modernizing an issue that came up related to findings and recommendations we have already, but even going beyond that, that was raised at our last meeting, was how state insurance law might be -- is creating barriers to innovation and payment reform.

So that's one example where we're looking at modernizing insurance law as a next step. Would this group want to contact with some experts from the National Association of Insurance Commissioners who have expertise in state insurance law to do an assessment and identify barriers in our existing state law and where law could be -- that law could be modernized, for example. So that's just one example.

The example that you just raised, a barrier to tele-medicine, is there a study the Commission could do and could

we convene a group to look into that issue? So what we're going to do at this next meeting is try to prioritize all of these little boxes and identify -- you all will identify what you think is the most important things we could do to help the system, the healthcare system to transform to achieve our vision to meet that central challenge.

What's the most important thing that we could do, and so I'm pointing to this. It's up on the screen right now, this matrix of importance and impactability, because then, the second aspect that we want to look at each of these boxes around is, I mean, what are the things -- what is the most important, what is most likely to move the healthcare system to achieve our vision, but also then, what will the Commission have the most impact on moving? What are those policy recommendations that additional work studies, convening stakeholder groups, whatever -- whatever form it might take, what will we make the biggest difference in, in terms of moving that policy recommendation forward? Yes, Dr. Urata.

COMMISSIONER URATA: Can you put that in monetary terms? If you look through all these things here and say, "This will cost this much and we estimate that this will save this much," and then we can just look at it in dollar wins,.....

MS. ERICKSON: I'm not.....

COMMISSIONER URATA: .....dollar losses.

MS. ERICKSON: I'm not smart enough. I think it's.....

COMMISSIONER URATA: I think there's an economist around that would try to take that on.

CHAIR HURLBURT: I think some of that work is done, that.....

COMMISSIONER URATA: Well, then we could just look it up.

CHAIR HURLBURT: Well, I mean that there has been attempts at that kind of analysis and then it becomes maybe somewhat of a personal judgment as to whether it's a bunch of garbage or not, but I think that there clearly is the intent and people trying to develop expertise and a discipline of what is the ROI? Where do you get your biggest bang for the buck? So that may be that could be part of the discussion. I don't think we have internal expertise, but -- because Peter's not here.....

COMMISSIONER URATA: But if you could get some evidence of that, but then you should grade the evidence, if this is good data, bad data, I don't trust it or something.

MS. ERICKSON: Yeah (affirmative), I'm.....

COMMISSIONER URATA: Or no data.

MS. ERICKSON: Yeah (affirmative), I'm afraid that would take us three years in and of itself. I -- to the extent that there is -- was some background research behind some of these recommendations that we've developed. I will point you back to our -- it's not going to give you a clear, easy, it'll cost this much to implement and we're going to save that much

money, it's just -- it's not that simple, but the closest we came to that was in early presentations that a health economist, Mark Foster, did for the Commission and I could pull up -- he did this thing that pertains to national studies and I looked at some at those models to come up with some recommendations that were focused on certain aspects of payment reform that were demonstrated at the time, demonstrating the greatest return on investment and ability to move the curve, so we could -- I could pull some of that up, but I think at this point, it's going to really have to be a judgment call and based on what we know already and going back and reviewing our -- the background finding statements behind these issue. Yes, Jim.

MR. PUCKETT: I haven't looked it up, but isn't the report by Mark Foster on the website for the Commission?

MS. ERICKSON: Yes, it is. It is, and so one of the things that I will do is make a point of sending a link to you of some of the presentations and reports he did for us in the past.

MR. PUCKETT: Okay.

MS. ERICKSON: I'm going to write that down.

COMMISSIONER URATA: Do you need a pen?

MS. ERICKSON: I'm going to check in and see if Senator Coghill is on the line with us, too, and see if he's been tracking this and if he has any questions. Senator Coghill,

are you there?

SENATOR COGHILL: Yes, I'm still here and with regard to the matrix, you know, it's that balance, the formula of cost and quality, you know, and availability. So that's what -- that's the formula that has to be put into that matrix, in my view.

MS. ERICKSON: And you're talking about the strategic map, the diagram?

SENATOR COGHILL: Yeah (affirmative).

MS. ERICKSON: Okay, well, because some of you are going to have, though, for October, is in advance of that meeting, again, to review the boxes and see if there's suggestions for improving the way those policy recommendations have been summarized and captured and organized, and then what I'm going to ask you to do, because we're going to go through a process to score together, both on a scale of one to five, for each of those and if we list them out, take them out of the boxes and list them out, there are about 20 categories of policy recommendations.

For each of those, you all as a group are going to rate those on a scale of one to five, its importance in transforming the system and impactability of the Commission's future work on moving it forward for implementation and what we might do is even give you an opportunity to give you a tool to do that on your own in advance of the meeting, and then --

so this is just --I need to check with our consultant.

One of the things I was thinking, is having you score it yourselves in advance, but then, as part of the conversation that will happen that morning, we get to give you three minutes to make a pitch to your colleagues around the table, "This is what I think are the one or two or three most important policies that we need to focus on and that we -- and that will move this issue forward if the Commission does more work on it."

So we'll have that conversation and give you a chance to make the pitch, but I don't know if you all have used an electronic voting system before. We have technology that you all with get a little -- a little box. You will be able to then punch in your score at that point, after hearing -- you can make your preliminary evaluation, and then after listening to each other's pitches, you'll be able to amend and punch in your prospective for each of those two aspects, for each of those 20 issues, and then we'll have the computer with us that, assuming the technology is working for us, will just spit out the average rank for each of those 20, on each of those aspects and we can populate the matrix together there and we can take a look at these different quadrants.

I would assume we're going to mostly focus on that quadrant that will group policies that are the most important and that the Commission would have the most impact in moving

forward, but not necessarily. We might -- there might be something that is not quite as important that would fall into the low importance box, but you might think is more important that the Commission focus on some -- getting something done and then we'd still move the ball down the field.

So we'll have a professional facilitator helping us with that process and that's how the process will work and we'll essentially be setting our agenda for the next one to two years. Does that make sense? Do you have any questions about the process and what your homework assignment's going to be? Okay, and again, I'll follow up with an email in the next week or so, laying this all out in writing and reminding you and providing links to some of this additional information. Mr. Chair.

CHAIR HURLBURT: Yes.

MS. ERICKSON: I was going to make -- I've been doing a lot of talking and this next discussion, actually, could be facilitated a little bit, if we can take a break now and then as part of the break, assign the group to look at a few slides in advance of the discussion. Would that be okay with you if we move our break up?

CHAIR HURLBURT: Sure.

MS. ERICKSON: Let's do that. Let's move our break, take a break right now. If you could come back to the table in about 10 minutes, what I'd like you to do is in your

discussion guide -- and I don't know what I did with mine. Do you have yours, Ward? Yeah (affirmative).

So this handout, if you can find this one, it was an additional handout that was on -- it should have been on top of your notebooks this morning and this is something I would have -- was hoping to get to you in advance and ended up traveling to spend the past week with my folks. My dad had surgery, and so this was one of the things that didn't get done in advance, but you have it here to look at it now and what I'm looking for, this is based on the conversation, back in the conversations around fraud and abuse that we had at our March meeting, and our June meeting, and where you all had been throwing out in our brainstorming sessions, different bullets about what you felt you had learned about fraud and abuse and also, ideas for recommendations you might want to include in this year's report.

Starting on Slide 19 and going through Slide 23, are at least the major issues around findings that you all had thrown out, identified, thrown up, not thrown out. Neither of those work and then what I heard from you all as potential recommendations are on Slide 24, 25, and 26, and so let's take a break for 10 minutes right now.

If you can come back to the table about 9:40, 9:42, somewhere around there and spend five or 10 minutes looking at these bullets and we'll spend some time up to what would have

been the end of our break, we'll probably take a short break when our presenters come in, but we'll spend the next half hour or so reviewing these to see if I've included something that you want to just take off the table.

We're not going to wordsmith this at all, but I promise I'll work on improving language after we make sure we have a complete list of findings that you want to make sure to capture and a complete list of the recommendations you want to include. So we'll do some adding and deleting and I'll clean it up, but we'll finalize it for -- in October for our usual -- and Susan, what we do is we'll identify draft findings and recommendations and a draft of our agenda for the next year, by the end of October and release those for public comment for, at least two, if not three or four weeks, during November, and then we come together in a final meeting in December, just to review public comments and to finalize our findings and recommendation statements and vote on those and also our agenda for the next year.

So this is something that will work into that, that process, okay. So we'll see you back at the table in 10 minutes. Thanks.

CHAIR HURLBURT: All right.

9:33:42

(Off record)

(On record)

9:53:56

CHAIR HURLBURT: Okay, we're going to get started. The little egg timer got stuck, a grain of sand got into it or something. So our 10 minutes when a little long. We want to talk about the fraud and abuse and this is particularly focusing on Medicaid, since we -- the two presentations that we've had, and I think that I've been impressed with, and I think you all have, and make us feel good about what the State is doing in the Medicaid program to attach that and relate to Medicaid, but we're seeing a recommendation today, assess -- or estimates that 3% to 10% of what goes for healthcare is related to fraud and abuse, and I think that's not unsurprising with three trillion dollars there, it is going to attract opportunistic people, because that's just a humongous amount of money, but clearly, it's not the holy grail.

When we talk about evidence-based medicine, it's about a third, probably, of cost. We talk about other opportunities to get it under control so we can continue to, both, have our economy thrive and have a robust, strong, high quality healthcare sector. If it's 3% to 10% at the lower end, that would be like twice the total gross domestic product for the state of Alaska that's fraud in the country and at the upper end of that estimate, it would be six or seven times the gross domestic product of our whole state.

So everything that we do and our spouses do and all the

rest of the state and all the oil we get out of the ground and so on, would be consumed many times over. So it's -- while it's not the holy grail, it is a significant part of money and as we repeatedly note, yes, this is absolutely a business, but it's a business with unique ethical and moral dimensions and that makes any fraud and abuse absolutely intolerable, so that if the bad apples can't be corrected easily, they should be shot. So with that, we'll turn it over to Deb.

UNIDENTIFIED SPEAKER: That's on the record.

CHAIR HURLBURT: Yeah (affirmative), right.

UNIDENTIFIED SPEAKER: That is not a recommendation.

MS. ERICKSON: It is not a recommendation. Okay, so I'm pointing you again to Slide 19, as a starting point for 11 different areas of issues that I've captured in draft finding statements here and again, I don't want to spend any time wordsmithing, you'll all have an opportunity to do that later, but I just want to make sure I've captured the main ideas, and I want to check in, too, to see if Senator Coghill is back with us.

SENATOR COGHILL: Yes, I'm still here.

MS. ERICKSON: Very good, because I will have a question, specifically for you at the end of the findings here, too, just to give you a head's up. So to the point Dr. Hurlburt was just making that it's not that fraud and abuse isn't important, but it's also not a major reform strategy. He had

brought that up a couple of different times in the course of our conversations and we had captured it in a bullet at one point, and so that's this first bullet and I don't know if we need to detract from the body of the findings and recommendations with this, but statement, but -- but didn't -- wanted to check in with you all to see if you thought it was important to start off with at statement that this isn't the holy grail, but it's important.

If there's no reaction or questions or comments, I'll just move on. Does that sound good?

UNIDENTIFIED SPEAKER: Sure.

MS. ERICKSON: And then the next point of what we learned about the proportion of spending for Medicaid, particularly, we're -- one of the things I point out to you is we're a lot more focused on Medicaid, particularly, in these recommendations, and especially in the recommendations, and a little bit in the findings, than we have been in the past, just because the recommendations that we'll make related to what state government can be doing about fraud and abuse, really have been focused on the state Medicaid program.

So it's a little bit different. We typically aren't focused just on Medicaid. We're more so in this area than we have been in the past.

We're ready to move onto number three. We had -- and Susan, we had a couple of different presentations by the same

group of folks representing both the Department of Law and the State's Medicaid program over the last couple of meetings and so these are just some of the highlights of information that they shared with us under number three. This new effort to increase collaboration between the two departments is really showing some results and so that's what this finding is meant to document.

Thank you. Barb's reminding me to change the slide, and it was noted -- I don't remember getting any data, so if you want to include this, I could see about pulling up some data on the backlog of cases that the Medicaid Fraud Control Unit currently has, but that was something that you all had called out in the brainstorming session at one point, too, so I included that as a finding.

Under number five, and again, I'm just going to keep moving along, so stop me if you want to stop and either ask a question or comment or make a suggestion. Yes, Jim.

MR. PUCKETT: I just kind of feel that number four is -- I mean, we're just saying that they have a backlog, but without a number of how many staff that they need, I think it's just kind of a very weak finding.

People will look at that and they'll say, "Well, maybe they just need one more person," I think. If there's any way that unit could provide a number, you know, from good numbers that they could back up, that would make this finding a whole

lot more relevant to people that are looking for something like this.

MS. ERICKSON: I'll follow up with them and get more information to add to this.

CHAIR HURLBURT: And I think that would tie back to Bob's earlier comment, maybe the rationale for what number and what would be the expected return on doing that and then that could be useful information to the Legislature in a very tight budgetary time, do they want to consider a request for an expansion, when expansions are going to be, you know, very small or nonexistent, so.....

MR. PUCKETT: Well, from a different tact, because I'm going through this quite a bit with my own Division is, some people may look at that and they'll say, "Maybe they just need to change their processes and be more efficient, maybe they just need to do some lean stigma in there in order to make up the back log." You see what I'm saying? I mean, there are people that would look at this in the public and come up with all kinds of things, unless there's something real definitive in the finding. Otherwise, it's just a very generic finding.

COMMISSIONER YEAGER: I totally agree with that, too, and even adding in like how -- what's the timeframe, what -- is it a delay of so many cases, of so many months, equaling so many -- like Dr. Hurlburt said, so many dollars of return, how many people does that mean, what kind, that would -- could be

action -- maybe acted upon.

MS. ERICKSON: Okay, any other suggestions? Yes, Emily.

COMMISSIONER ENNIS: Actually, for number four, no, number five, so if we're not there.

MS. ERICKSON: Yeah (affirmative), we're at number five.

COMMISSIONER ENNIS: Okay, we're at five, too. So again, this is an interesting, you know, suggestion and definitely I'm surprised that we don't have any good way to recover funds that are lost and so I would recommend that we, you know, consider looking at what other states are doing, if there are any successful recovery processes or statutes that have helped and then again, as we were listening to the presentation by the folks, it did seem like, you know, some were definitely, you know, a very serious criminal element and whether or not, you know, there are other measures to prevent, you know, not just your average provider that decides, you know, to find a way to bring in some extra revenue, but you know, there are some very significantly well-planned scams that are going on, and you know, taking another look at how other states, perhaps, have been successful in preventing those even from getting started.

MS. ERICKSON: Other comments on number five? Okay, I'm going to move onto number six, and this was specific to the new Medicaid RAC program that was required under the Affordable Care Act and we had learned that a relatively new

RAC contractor had essentially quit because the methodology that is used nationally for the RAC program doesn't -- isn't used in Alaska. Okay, and moving.....

CHAIR HURLBURT: And I say, you know, that's an important point to make because it's probably going to be unavoidable, but you want to minimize it, that there will be a harassment factor associated with your anti-fraud program that will adversely impact the overwhelming majority of providers who are not engaging in fraudulent practices.

So to be responsible in making recommendations, I think it's more balanced, it's more fair, it's more even to say, "This doesn't make sense. We don't need to do it," because any of these things, you know, will give Bob a hard time or Julie a hard time or that -- and then we want to minimize that and avoid that.

MS. ERICKSON: The number seven is related to the new provider enrollment system that will someday be operational under a new MMIS and the value that will add. The -- and just a finding about the Myers and Stauffer audit. It's the state audits that are mandated under state law.

There's a recommendation associated with that. So I don't know if we fully identified the issues in this finding related to the recommendation, because we did make some recommendations related to streamlining that. So that's something to just keep in mind.

A couple of areas where our experts had identified that fraudulent providers are exploiting vulnerabilities in the system and the fact the Medicaid recipients don't receive an EOB and so they really have no way -- they don't have any incentive, in the first place, to participate in identifying fraudulent practice and then they'd have no way to check to see if somebody, their provider or anybody else, might be billing for services provided to them or in this case, not provided to them, and then also issues related to the lack of enrollment of some of the rendering provider types. Yes, Wes.

REPRESENTATIVE KELLER: The slide.

MS. ERICKSON: Sorry. Okay, if there are no comments or questions on these, I'm just taking no response, as go back and clean up the language, but keep this concept in for a finding. So for number 10, this was related to the issue about the barrier that's created in the state law that creates the prescription drug database that prohibits the Department of Law and the Department of Health and Social Services for accessing that data.

COMMISSIONER URATA: So that's a recommendation that.....

MS. ERICKSON: There is a recommendation associated with this finding, yeah (affirmative).

COMMISSIONER URATA: All right.

MS. ERICKSON: We'll get to that in a second, and then I just wanted to check in with Senator Coghill, particularly,

this last number 11 finding related to behavioral health, this was an issue that came up in our March meeting that I remember Senator Coghill raising and it was captured in one of our bullets, but it wasn't something that we learned about or discussed at any point and I don't think we have any findings or recommendations related to it.

So I wanted to see if you, either wanted me to find additional information or if we should take it off the table for now?

SENATOR COGHILL: We probably should just take it off the table because I think that's something the Commissioners have been working on, the accountability for the application for the grant. So I think that's -- I'll just take it off the table.

MS. ERICKSON: Okay, we'll do that, and so then moving onto the -- yes.....

COMMISSIONER YEAGER: Deb, this isn't -- I was wondering is there -- just back on number 10, was there any kind of a finding, it talks about the Department of Health and Human Services, you know, they're not able to access the data, using it for potential fraud, but was there any finding about -- in terms of over, like redundant medications, and what I'm trying to say is that you see a lot of veterans who come to the federal side and we know if they're being seen in the private sector, they could have prescriptions for the same medication

or different medications for the same condition and we don't have anyway right now, I don't think, of knowing what they're getting.

We try to do a medicine, you know, medication reconciliation every time, but it's up to them to tell us. If there's any way we could share any of these databases or somehow cross-check who's getting what prescription where, I think that would be a quality and potentially a cost savings.

CHAIR HURLBURT: It was very specifically addressing that. We do have the prescription drug management program here. It was federally funded. We allot our federal funding and Bill Streur skirted around and found enough money to keep it going, but it's not very real-time and astoundingly, Chad Hope, the Chief Pharmacist in the Medicaid program, is precluded from seeing that information, which makes absolutely no sense to me, to speak in a muddle way, I guess, but so it was very specifically addressing that and the discussion had been to move toward a more real-time prescription drug management program, to not lose what we have, because in a tight budget time, what we have is very important and it is a major issue.

Larry's been involved in a lot of that and has provided a lot of good guidance on that, but to improve what we have and to enhance the access and you're right, your patients move back and forth and to different sectors, you know, they may go

here. If they're Alaska Native, they may go to ANMC or South Central and tomorrow, they may go over to a private clinic somewhere, so that we do need to make sure that all those kinds of people, including those managing the Medicaid program for the state, like the Chief Pharmacist, have access to it, but yeah (affirmative), absolutely, that's very specifically what it was targeted to. Larry, yeah (affirmative).

COMMISSIONER STINSON: The VA should be able to access the state program. It's up to about a two-week delay, but even with that, it's been very, very helpful and yesterday, one of the first people I saw, everybody we see every day, we access on our schedule that states -- and printout what they've been getting and the first person I saw was multi-sourcing and we had a conversation about that and it is helpful. Real-time would be ideal, but even with that, it's still quite helpful and there's no reason why the ANMC or the VA, the federal healthcare agencies shouldn't be able to access that, and I also totally agree that if the state Medicaid HHS is paying for things and they can't even find out who's getting what from where, that makes absolutely no sense to me.

UNIDENTIFIED SPEAKER: How did that get (indiscernible - too far from microphone)?

UNIDENTIFIED SPEAKER: Privacy, privacy issue.

MS. ERICKSON: Go ahead, Keith. Keith, go ahead.

COMMISSIONER CAMPBELL: What action would it take to overcome these barriers?

MS. ERICKSON: We would need a legislative bill introduced, so we can -- we're getting to that right now. The -- so what I will do is work on strengthening and adding more to that finding number 10, to address, not just the fraudulent describing practices, but also that doctors not being -- and then also the -- expand on the access issues a little bit more. Yes, Jim.

MR. PUCKETT: Does it require a new law or just amending the current law?

MS. ERICKSON: Amending current law. Okay, so moving onto Slide 24, wait, before I move on, I just wanted to note that our presenters for the presentation that was to start at 10:15, are in the room and we're probably about 10 or 15 minutes behind, but we'll get started before long.

Okay, so on Slide 24, is where we're starting with the draft recommendations. So the first -- what I did, these were all separate bullets and I pulled them all together, all of the bullets related to things that the Commissioner of the Department of Health and Social Services could do and specific to addressing fraud in the Medicaid program, because there's another section for him about that call management, it's the last recommendation, but these are all of the things that presumably, the Commissioner could do without additional

authority.

So there's a list of five different issues here establishing regulations to enroll and I'll -- by the way, I'll confirm, too, before we finalize this, these really are things he could do, whether he wants to do them or not, whether these are the things that he could do under his own authority.

So establishing regulations to enroll all rendering provider types, that was something you all had identified in the brainstorming session. All of these are things you all had identified in the brainstorming session, but repurposing the discretionary audits. This is related to the state audits that Myers and Stauffer performs for the Department.

The -- reducing cycle times for notifications to providers and streamlining that process and improving access to information for providers, undergoing the audit or investigation process, providing an EOB statement to Medicaid recipients, the explanation of benefits statement, and also requesting a waiver from CMS for that Medicaid RAC program.

Do any of you have any questions or comments or concerns about any of those? No, okay, moving on then to recommendation number two, this was just, again, came up in conversation, the recognition of the accomplishments that have been achieved for the work, the improved collaboration from those departments and directing the Commissioner and the State

Attorney General to continue working on strengthening that collaborative relationship and processes. Any thoughts on that? Keep that one in?

Number three, then, now, this is related to the finding that you all said really needs to be strengthened, is that the Legislature funded the Governor's support expanded capacity. So I don't know if you would want more specificity in there or we'd leave it to the Legislature and the Governor to figure out. Yes.

COMMISSIONER STINSON: Would that include DHSS, too?

MS. ERICKSON: The way this is worded right now, it would not.

COMMISSIONER STINSON: Should it?

MS. ERICKSON: We -- we heard specifically about the backlog in the Medicaid Fraud Control Unit. I don't remember hearing about staffing issues, that doesn't mean they don't exist, I don't remember that coming up in the presentations or the discussion, department capacity issues.

CHAIR HURLBURT: I think in asking for some of the details Jim suggestions, which I think will be helpful, whether it's expanded in the recommendation or it's kind of material that goes along with it, we could ask and then clarify that, because we did come across it. It was specifically in the -- in the Department of Law, but you know, if they were helped and then the roadblock became the Medicaid

program, we would -- and they should be able to tell us that.

MS. ERICKSON: Yeah (affirmative), and I'll -- when I'm gathering that additional information for that finding, I'll try to do that, associate it, and look at the other department, too. I am remembering, and I don't think I captured it here in the brainstorming session, that one of you had raised the point that the Department of Health and Social Services were request -- were recommending that, I mean we had just went through that long list of things they should do, including promulgating new regulations and adding new provider types, essentially, that the Department might need capacity to do those other things, too, and we've been -- so that was raised. I didn't capture that here, though. So I can ask that other question.

So then number four, these are all issues that will require legislative action, bonding for Medicaid providers and strengthening the seizure and forfeiture. So Emily, to your point about the finding, now here's a recommendation associated with it, and I don't know if you have questions or concerns about that. Keith.

COMMISSIONER CAMPBELL: I'm trying to understand the bonding recommendation, would it be one bond number for every provider or because it's, you know, there's a whole range of dollar amounts of each provider comes -- or would it be a bracketed bonding capacity, because you could kill somebody

with bonding capacity and the prices of it, so.....

COMMISSIONER STINSON: Defer it to the Legislature.

UNIDENTIFIED SPEAKER: Yeah (affirmative), thanks.

MS. ERICKSON: Would you ask like me to ask Andrew to provide some additional information? He was the one -- Andrew, and Susan, Andrew Peterson is the Assistant Attorney General, who's the head of the Medicaid Fraud Control Unit, and this was a suggestion that he had raised. So we can ask for more information from him related to this suggestion he had.

REPRESENTATIVE KELLER: If we could, when you request the information, ask him for the actual numbers, you know, like what it costs, you know, now for some of these bonds that are out there, so we have something to think -- you know, a reference point.

MS. ERICKSON: Okay, and.....

REPRESENTATIVE KELLER: Another question.

MS. ERICKSON: Senator Coghill was just trying to say something, too. Senator.

SENATOR COGHILL: I got interrupted by Wes.

REPRESENTATIVE KELLER: I'm sorry. That's all right, touche. No.

SENATOR COGHILL: Probably what we would look for is a schedule that shows what the bonding requirements and the service delivery (indiscernible - interference with speaker-

phone). For example, you might have somebody delivering a lower level of service that just doesn't need a huge bonding and so it probably would be a schedule where the bonding suited the service.

MS. ERICKSON: That's helpful. Yes, Bob.

COMMISSIONER URATA: And so I was under the impression that medical clinics would not be -- or hospitals would not be required to have that, but I was thinking they were like home care programs and personal care attendant programs, things like that, but I could be mistaken, so maybe that could be clarified, too.

MS. ERICKSON: Yeah (affirmative), I'll ask for that clarification, too.

CHAIR HURLBURT: Yeah (affirmative), my recollection was the same as yours, Bob.

COMMISSIONER STINSON: I agree with Bob because the problem with the other places is they were shutting down, going away and then reorganizing. You don't get that with a hospital. You don't get that -- well, you shouldn't get that with a clinic. So I think that's the target.

MS. ERICKSON: I'm just taking a few notes, for folks who are on the phone. Okay, one more, and this was more in, not so much to fraud and abuse, but to the waste issues and some of the initiatives we learned about related to medical management. So these are all directed to the Commissioner of

Health and Social Services again, specific to improving medical management to address waste concerns in the Medicaid program.

COMMISSIONER URATA: I have a question.

MS. ERICKSON: Yeah (affirmative), go ahead.

COMMISSIONER URATA: Can I make a point? I get a little bit of heartburn with 5A, expansion of prior authorization requirements for medical necessity. We get -- we spend a lot of time or our nurses do or our medical assistants spend a lot of time trying to get things preauthorized and in one case, I was told by a nurse, it took four hours and she was really mad, and she took it out on me.

So that's why I remember, and the majority, if not all, eventually get authorized, you know, because I think that most of them are valid therapies that we're going through. So you know, I think I emphasized this in the last meeting, it's really important to make sure that if you're going to expand, that they be very efficient and take short time, and I would like to see them do quality improvement on how long it takes to preauthorize certain things with a particular clinic and with a nurse involved or whatever.

I'd like it to be less than an hour, but you know, they also -- there is also a new means of doing it through the internet, as you fill out all the forms and all the questions and apparently, that takes a little bit longer to do than

actually doing it in person, and of course, when you're working with a person, that's a little bit easier, as opposed to doing it -- because when you send in your form, you don't know when you're going to get an answer and sometimes it's the next day, you know, and you have to check your emails and so I -- yeah (affirmative), I think it's important to have -- perhaps it's important to have preauthorizations. I'm not sure -- it'd be interesting to see numbers on how many -- how much money you save by doing preauthorization, because I know it's costing us a lot of money to do preauthorization.

CHAIR HURLBURT: And I think that from where you're sitting, that would be an absolutely normal reaction. As an example, when I worked.....

COMMISSIONER URATA: Well, that's a real reaction.

CHAIR HURLBURT: When I worked for Pacific Care, for some reason, they created an internal experiment where they removed the prior authorization requirements for complex diagnostic imaging in Oregon and not in Washington, and the enrollee population size was about the same and very comparable in both states.

The utilization rate for these expensive complex diagnostic imaging studies bumped up 20% with not having that there, but I think that the point you make, and Lydia Bartholomew joined us as a Senior Medical Director with Aetna for the Northwest, I'm sure she would absolutely say, "Amen,"

as would I, that the comments that the process should be as user friendly and as efficient as possible for providers and there is opportunity to be more so, because what you described is not reasonable. It should be something that both saves money and enhances quality of care, but it should not be a harassment.

COMMISSIONER URATA: Well, I think that's what (indiscernible - too far from microphone).

MS. ERICKSON: Should we add an additional statement related to this or just add onto A, and include improve and streamline the process?

CHAIR HURLBURT: I -- yes, I think to capture something like user friendly and efficient for providers, that if that kind of a system is going to work, it needs to work in that way.

MS. ERICKSON: Yes, Wes.

REPRESENTATIVE KELLER: How about something to include increase patient responsibility to get prior authorization? That wouldn't affect the provider, would it? I mean, in other words, whoever the carrier is, I just -- I just thought of the question.

CHAIR HURLBURT: But the provider will be the one that will have the clinical information and where it comes into play, the vast majority of situations, you're not going to have a requirement for prior auth, then the big majority where

you have to have it, it will be cut and dried and it will fit the standards, either the practice guidelines that Aetna has or Milliman or Innerqual, some of these nationally recognized standards, but then the ones where there's more of a judgment, you really -- you do need to get the judgment of the provider.

That's also why, in any prior auth setting, unless it's just a coverage issue, only a physician can say no. A clerk can't say no. A nurse can't say no. It has to be a physician that says no, and you need to have the ability, if they want, for the provider to have the conversation to say, "This is why it makes sense. This is why there should be an exception. This is why it should be done," but it still should be user friendly and efficient.

MS. ERICKSON: Okay, moving on, I wasn't going to go through all of these point-by-point, but is there anything -- any other issues in any of these other six that are listed here that you would -- that you have questions about, that you would want to exclude? Is there anything missing?

COMMISSIONER YEAGER: This is Susan. I wasn't there for the discussion, but I'm kind of a little concerned about F, and I don't know quite what is meant by that, investigating beneficiaries who pay cash for prescriptions. I'm assuming it's because there's an idea they have multiple prescriptions at different places, but it seems.....

CHAIR HURLBURT: Yeah (affirmative), you might need to

put a reason for that, a simple statement.

MS. ERICKSON: Yeah (affirmative), explain -- just add more explanation to that, okay. I'll do that.

COMMISSIONER YEAGER: It's just kind of a concern, I think we're going to (indiscernible - speaking simultaneously).....

MS. ERICKSON: That was -- that was the issue, Susan. Yeah (affirmative), I'll explain that a little bit better. Any other questions or comments? Senator Coghill, are you good with where we're at right now?

SENATOR COGHILL: Yeah (affirmative), I think I'm pretty good. Just for your information, at about five minutes to 11:00, I have to leave for the day. My other duty will crowd in, so -- but I think the recommendations sound pretty good. Thank you.

MS. ERICKSON: And thank you very much. Thanks for joining us for the morning. So what I'll do is work on refining these and improving them and getting the initial information included that you asked, and we'll have another go at it to finalize them then for public comment, before you have a chance to finalize them and vote on them at the end of the year.

So we're going to have just a very short break to bring our next presenters up to the table. Our -- we're going to spend the rest of the morning learning about rural sanitation

in Alaska and so if I can bring our presenters up, we'll get the presentation set up and reconvene in about five minutes.

10:29:59

(Off record)

(On record)

10:33:58

CHAIR HURLBURT: Okay, let's come back together and we're just getting the session organized now, but we'll try to make this a real five-minute break. I know we're (indiscernible - speaking simultaneously).....

UNIDENTIFIED SPEAKER: (Indiscernible - speaking simultaneously).....

CHAIR HURLBURT: Because we're already running a little late. In -- before I came onto the Health Care Commission, in one of the various, earliest meetings, when it was just established by the Governor, there was a recognition and comment about the importance of the water and sanitation programs and so on, and so as I was just sharing with our colleagues here, this has not been the thing we've spent a lot of focus on, but this is so huge and it's so important and we wanted to bring this back.

A personal story is when I first came to Alaska and went out to Dillingham back in 1961, the hospital, the average daily census was about 24/25 at that time and it's probably about four or five now, for a much bigger population than we

had then and about half of that were sick infants, a lot of kids we saw with purulent otitis externa, which was pussy, runny, it was common as a cold, when you see puss running out of the ears of the Alaska -- little Alaska Native kids who would come in, lots of bad gastroenteritis, salmonella, shigella, typhoid, even there, and so then some of the medical care that I provided, for example, for the otitis media was probably almost as good as witchcraft and usually, when -- if I'm talking about that in a meeting with pediatrician friends, I ask them to close their eyes, because it was definitely not evidence-based medicine, but we thought that was the right thing and it went away.

In fact, for a while, we got to where it was more just a serous otitis, which is a collection of fluid in the middle ear, that you saw more in the dominant population in the U.S. at the time and that's continued to get better, and obviously, that's really due to the wonderful things that people like Larry and Bob and I did to get that better. However, in fact, it was housing, water and sanitation that did that. I think in that particular situation, there was zip that I did.

We had the best gastroenterologist, best pediatric otolaryngologist in the country from the big academic centers, "The reason you have a problem is because God created Alaska Native babies in the wrong way. You need to do an otolaryngologist tonsillectomy and adenoidectomy as soon as

you can semi-safely put them to sleep," and so there were big T&A clinics on cots, you know, log cabin, in a community with an operation that's technically simple, speaking as a surgeon, but like anything else that we do, fraught with complications. You can bleed and so you had an otolaryngologist and a nurse anaesthetist that would go and yank out the tonsils on all the kids and off to the next village and fortunately, they didn't see too many people die, but these are the guys that made that kind of difference and it has remained a challenge that's -- I came into Indian Health Service before we really had much money and then we started getting money.

It's been a big program with Indian Health Service dollars through the Department of Health and Human Services over the years. The HUD's been involved and the state has played a major role in that. We still have significant numbers of communities and villages in Alaska because of the challenges of Arctic construction and remoteness and all that, so it's an ongoing challenge, but the percentage, I think, is about 80% now, I believe, of Natives' homes have water and sanitation.

Well, I spent a couple of years in Liberia and the U.S.A. had a funded project contracted with Indian Health Service developing a model rural healthcare system. There was no money in that for water and sanitation. These were communities where people were digging shallow wells or getting

water out of a stream where they were defecating upstream and washing their clothes and so on, and I brought the Minister of Health over here and we toured some of the villages in Alaska and then he was totally supportive of stealing what money we could from drugs and other things to put it into putting in wells, because that was what was needed there and that's what's been needed here.

So I appreciate you guys coming. I appreciate the perspective you do and the critical role and the reminder that -- what I learned in kindergarten stands as good in life and the water and sanitation that we all learned when our moms taught us to wash our hands and flush the toilet and do things like that, are important. So I'll turn it over to you all. Tom, are you going to start or -- okay, thank you.

Let me -- yeah (affirmative), Tom Hennessy is the Director of the Arctic Investigations Program, one of the premiere programs that CDC has in the country and has been an incredible resource for Alaska and with a really impressive collaboration between the state and the Tribal Health system and CDC on this over the years, made huge differences and had a positive impact here in Alaska.

Bill Griffith is with the state and as I mentioned, the state, over the years, has played a major role in the water and sanitation area, again, working collaboratively with the other entities there and so Bill comes, and then Mike Black,

who's with ANTHC will come in and -- with the perspective of what has come through Indian Health Service dollars over the years when the federal government operated the program and now, as beginning 25 years or so ago and then growing, but increasingly, as the program has been operated by the Tribal Health System and of course, the folks operating the Tribal Health System and those who use and "own" that system now, remain very articulate and strong advocates because they do recognize how important that is, both to the health of the Alaskan Native people in the Bush and their quality of life and so Mike comes reflecting that. Tom, do you want to go ahead?

MR. HENNESSY: Great, well, thank you, everyone, for inviting us here to talk about this important determinant of health and as Dr. Hurlburt said, I'm going to talk about how water and sanitation services affect health in rural Alaska.

Some of you may not be familiar with our program, but since 1973, CDC has had a field station for infectious diseases located on the Alaska Native Medical Center campus. I'm the Director of that program and we have laboratorians, physicians, nurses, statisticians, who work to reduce the morbidity and mortality due to infectious diseases in Alaska, and we work very closely with ANTHC and other tribal partners, as well as the state of Alaska. So we try to augment the capacities that are here in the state.

I first started getting involved in this issue when we were investigating a boils outbreak in Southwest Alaska in 1999, and we recognized very quickly the important role water had to play in propagating or lack of water access in propagating that epidemic.

Since then, we've been providing data to help support what Mike and Bill are involved in, which is the construction and delivery of water services in Alaska, and the data that we provide is linking the health outcome to the services that are provided. So that's what I'm going to focus on during my part of this talk, is on the health components that we know are connected with water service in Alaska.

So this first slide here shows data from the U.S. Census on the proportion of homes in the United States that have complete plumbing and we've been tracking this in the U.S. since 1940. The yellow line shows that of the overall U.S. population, 99.5% of the U.S. has complete plumbing in their homes, which means a sink with running water, a flushing toilet and a bath or a shower.

Alaska ranks last among all U.S. states in the proportion of homes that have running water. Although, we're at about 95% overall, and the reason for that, obviously, is that the lack of water service in rural Alaska, which is, as Dr. Hurlburt said, about 80% of homes in rural Alaska have complete plumbing, 20% don't.

That puts us, for rural Alaska, about on par where the U.S. was in 1950. Now, we've made great progress in Alaska, but for communities that live without water service, it's quite a detriment.

This is other data from the U.S. Census, from the American Community Survey, which is a sampled survey of homes and what they do is they apply this to the census and ask a subset of people about different aspects of their home environment. Water and sanitation service is one of those, and then they rank all the U.S. counties according to the level of water service and I've just listed the top areas in Alaska census districts and the portion of homes that are estimated to not have running water or complete plumbing in those homes and you can see that out of the top 10 counties in the U.S., seven of them are in Alaska, in terms of lack of service.

So it's a considerable problem, and for rural villages, if you live in one that doesn't have running water, life can look somewhat like this. A child in the upper left-hand corner. I have to keep looking over my shoulder to make sure I haven't altered these in some way.

The child in the upper left-hand is taking human waste from the home from a honey bucket and depositing it in a hopper outside the home that will be carried to the sewage lagoon. The fellow on the upper right-hand corner is a four-

wheeler, and he's getting drinking water, clean drinking water at the water treatment facility and he'll carry it back to his home and probably store it in something like a 55-gallon plastic drum or a trash can there for home water use, and then the lower right-hand corner is a sewage lagoon in the winter with those cubes of human waste there that the villagers affectionately call poopsicles. So this is an intensely labor -- this is a labor intensive process and it results in a lot of opportunities for cross-contamination and it also causes problems with water rationing, too.

We've known about the relationship between water, sanitation and health for a very, very long time. The Romans recognized it. This study that I'm showing here is from eastern Kentucky. It's kind of the classic study in the United States that shows the value of having in-home water and a flushing toilet in homes for prevention, both of parasitic infections and diarrheal causing diseases.

So it's no surprise that we would make the connection here in Alaska, and when we started asking this question, does the lack of in-home water and sanitation services affect the health of rural people in Alaska, a colleague of mine said, "Well, this is sort of a parachute question, isn't it," and I didn't know what he meant by that, but he said, "Everybody knows that parachutes are useful in preventing death from jumping out of airplanes, but nobody wants to study it and

nobody's going to put any energy into that," and so we weren't doing this for an intellectual purpose, but really to provide data to help support the value of healthcare, value of water service delivery in Alaska.

So I'm going to show you some of the elements that we've generated locally in Alaska and some of the evidence that helps support this. An important thing to realize, and this is somewhat self-evident, but it's worth stating, is that if you're hauling water, like these people on the right-hand side of this photo, they've dug a hole in the ice. They're dipping water out. They're packing it back to their home. They can only carry so much water and they can only store so much water in their homes, so it leads to water rationing and typically, by a hierarchy that's recognized, as shown on this slide here.

So people are going to first use water for drinking and cooking their food. Personal hygiene is going to follow that. Washing clothing and cleaning their homes will follow that, and so personal hygiene suffers in these home environments and we know that. It's been widely recognized and that leads to a lot of the health consequences.

When we think about infectious diseases and water, there's kind of four buckets that we can put infectious disease activities into. The first one is the most widely recognized, and these are water-borne pathogens. These are where the pathogen is ingested along with the water and it

causes typically diarrhea. So cholera is the classic example of this and this is an issue of water quality.

The second major grouping is with what we would call water-washed diseases and these are conditions that are basically transmitted person-to-person or through self-inoculation of pathogens and this typically results when you have a lack of water for hygiene, and the classic examples would be skin infections or trachoma, eye infections. This is really an issue related to water quantity, not so much water quality. The other two categories are less common in Alaska and I'm not going to address those here.

I'm going to skip this slide, in the interest of time, and show you these local data from Alaska. So when we first started looking at this issue, we used locally available data and just looked at the correlation between water service delivery and health for a number of health outcomes.

So this is from a publication in 2008 where we looked at hospitalizations for diarrheal disease, pneumonia, respiratory syncytial virus, which is the number one cause of hospitalizations for children, skin infections, and a particular kind of bacterial infection, MRSA, which is a drug resistant form of staph aureus, and what we did, is we characterized communities in Alaska according to whether they had high or low levels of water serving, using a cut point of 80% and what we found, actually, was a little bit surprising.

The first surprise here is that diarrheal disease hospitalizations are not different at all around different regions in the state and we think the explanation for that is what Dr. Hurlburt alluded to earlier is that we -- in every village, there's a provision of drinking water that's clean and safe, and so a lot of the water-borne infections have been addressed already by the activities by the state of Alaska and the Indian Health Service.

However, the remaining conditions, all of which are higher for regions in our state that have poor water service, these are all water-washed diseases, pneumonia, respiratory syncytial virus, skin infections, are all person-to-person transmitted that can be transmitted on an individual's hands and the transmission can be interrupted by washing your hands, but if you're rationing water for drinking and cooking, you're not doing as much handwashing and you end up with higher rates of these diseases. So that's what we think the connection is.

We look -- I think I went one ahead, there. We looked a little further and these are data from our laboratory where we track infections due to pneumococcus and pneumococcus in the most common cause of otitis media, pneumonia and bloodstream infections, and these are serious infections with pneumococcus. So these would be meningitis infections, bloodstream infections, severe joint infections.

We've been tracking these in Alaska since 1986. These

data are from 2001 through 2007, focused on Southwest Alaska, and these are for children under age five, and what we did, is for each of these infections, we categorized whether the child came from a village and what the water status was in that village and we put them into three categories, whether less than 10% of the homes had water service, whether 10% to 79% of the homes had water service, or whether 80% or more had water service, and you see this stairstepping, decreasing rate of serious invasive disease with the increasing levels of water service, and the yellow bar there shows the rate, overall, for the United States.

So the point about this is there's a huge health disparity in rural Alaska for these very serious infections and that water service in the community seems to be associated with lower rates of disease.

We took the same approach, and this next slide basically shows the same layout of data. These are for hospitalizations for Alaska Native infants, again, according to the percentage of homes in the community that had water service and we looked at three outcomes, lower respiratory tract infections of any kind of pneumonia basically, X-ray confirmed pneumonia is the middle group, and RSV infection, and we see the same pattern in each of those.

I've added in here the town of Bethel, which is shown in red there, just as a comparison. Bethel has water service

delivery to every home and so it's a good comparative because it's an -- it's of the area, but it's a completely served community, and again, the U.S. rates are in yellow.

I want to contrast the rates of disease difference between the town with 100% water service and the villages that have less than 10% service and just point out that there's about a 35% difference in these hospitalization rates in those areas.

So that's sort of a rough guide, is what you might be able to expect if this relationship held up and we're able to provide water service completely for all those communities. We might expect, at the most, a 35% increase -- or decrease in disease.

This slide shows skin infection rates for persons of all ages, again in Southwestern Alaska, with three different outcomes, staph aureus infections, drug resistant methicillin-resistant staph aureus, and persons who were hospitalized with these infections and we see the same type of relationship, and again, comparing rates of disease this time for the drug-resistant type, we see about a 50% difference in rates of disease in the town versus the villages that have the lowest rates.

So these data are useful, I think. They point out something that we probably all would have predicted. The data holds up in a biologically predicable way and it repeats sort

of what we've learned over time. So there's nothing real remarkable about this or terribly controversial, but they are look-back data and we're just kind of putting two data sources together and it doesn't account for all the factors that you might want to look at.

So we continue to ask the question, "What happens when communities receive in-home pipe water service," and we used an opportunity that was occurring in Southwest Alaska where four villages were going from honey buckets, hauling water and hauling waste, to getting piped services and we set up an investigation to evaluate what happened in those communities.

So we've studied them from 2007 through 2012, and we looked at health outcomes and water service use in those communities and these are some of the early data analysis and this is one of the first public viewings of this. So these are not yet published, but we're at a point, I think, where we can share them.

One of the things we found, not surprising, is when you go from hauling your own water to having piped in-home service is that water use increases a lot. It went from about one to two gallons per person per day to about 25 gallons per person per day. That one to two-gallon mark is below the level that the United Nations would recommend for refugee situations, such as you might see in Africa with displaced populations. They recommend around 10 or 15 gallons per person per day for

drinking, cooking, and hygiene, and so people in rural Alaska are getting by with a lot less water than we would provide if we were going to set up a refugee camp.

Twenty-five gallons per person per day puts people into the range where they're -- have adequate water for drinking, cooking, and hygiene also. We also know that there's probably improved hand hygiene as a result of this, because in these communities, we've provided liquid soap on a weekly basis and measured how much soap people were using and it increased dramatically along with water use.

We also saw fewer infectious disease clinic visits in each of these villages. Respiratory visits went down by about 20%, as did skin infections, and interestingly, visits for diarrheal diseases went down about 40%. Now, this is still much less common than the visits for either skin infections or respiratory, but a lot of these visits for diarrheal disease also decreased. We heard from people, not surprisingly, that they felt healthier, that their kids were healthier, and they were happier with having in-home running water.

I want to shift gears a little bit and talk about another health condition that sometimes gets excluded in this discussion of water and that has to do with dental caries or cavities. The photo on the left shows a child with very mild caries. The child on the right, unfortunately, has lost four of his front teeth to caries and this is a common problem in

rural Alaska, all too common and we really have an epidemic of dental caries in rural Alaska.

We were asked several years ago by the YK Health Corporation to get involved in this topic and we went out and did a survey in five YK communities in 2008, and found, similar to what's been done in other surveys, we found that almost 90% of four to five-year-olds had some cavity experience and this is a rate about five times higher than the general U.S. population, and during that year, on residents of that YK Health Corporation, there have been 400 full mouth dental restorations done.

Now, their birth cohort every year is about 600 children. So this is approximately 20% of four to five-year-olds undergoing a surgical procedure for caries every year. These are rates not seen anywhere else in the United States. So in looking at this, I'm going to pause a second and talk a little bit about full mouth restorations, because I think they'll be of interest to the Committee here.

This is a procedure done under general anesthesia. It requires an oral surgeon or a dentist and an anesthetist, in which time, they'll do multiple tooth extractions and they'll do restorative procedures, such as fillings, or in the case shown in this picture, they'll put stainless steel crowns over the teeth.

The cost is about $9,000 for a child in the Bethel area,

which includes travel costs to bring the child and their parent to the -- to have the procedure done and most of these costs are borne by Medicaid.

So it -- we asked the question, "Are dental cavities a water-washed disease," and I think there's good reason to think so, because access to in-home running water, we know can affect toothbrushing habits. It's harder to brush your teeth if you don't have running water, maybe less incentive to do that if you're -- if you're trying to ration water and it doesn't become as good a habit.

It may also increase soda consumption. People are rationing water. In villages, soda is cheaper than bottled water and to kids, it tastes better and so we wonder also if soda consumption, which is a major factor in dental decay, if that's in some way related to lack of access, and it's also definitely linked to lack of access to optimally fluoridated water.

Of the 48 villages in the Bethel area, only five of them have optimal water fluoridation. Seventeen others could fluoridate because they have the piped capability and the size of the system and the equipment available, but they're not currently doing so and that leaves 26 communities that could not receive piped water because they basically on a hauling water system and they're not allowed to do that. So we're missing opportunities to prevent dental decay by not having

optimal running water in villages.

This is also from that 2008 investigation we did where we looked at the number of dental caries in children in their primary teeth and in their permanent teeth, according to the fluoridation status of the water in villages and there's two groups of bars here. One is for four to five-year-olds. The other is for six to 11-year-olds, and the height of the bar is the number of carious teeth in the child's mouth and you can see that the orange bar there, those are children that came from villages that don't have fluoridated water delivery systems and they have a threefold higher rate of caries compared with kids that come from a fluoridated system and then the U.S. overall is shown in green. Yes.

COMMISSIONER CAMPBELL: Do you run into the horrendous competition and fights that we have in this area about fluoridation and non-fluoridation and all this sort of thing? The -- we've had, in our community, we've had some terrible community-splitting.

MR. HENNESSY: Yeah (affirmative), the issue has come up in a number of ways in Alaska and as you know, Juneau stopped water fluoridation in 2006, and in Fairbanks, I think, in 2010, and it's come up before the Anchorage Assembly also. The -- in rural Alaska, about the time that we published these data, the question came up in Bethel and they voted to maintain water fluoridation, and in fact, in recent years,

we've had our best progress in rural Alaska communities in wanting to fluoridate their systems.

So Bethel maintained it. Nome is adding it back into their water system. There's a number of villages that I listed in the Bethel area of those 17 that could fluoridate that are exploring actively adding water fluoridation. So I think this local data helps. I think people recognize the value of that and in rural Alaska, it may be less of an issue than it has been in some of the urban areas.

CHAIR HURLBURT: Nationally, we're still seeing small gains and we're up to, what, about 75% of the people on public water supplies are fluoridated and continue to slowly go up. We're going down in Alaska. Anchorage, whereas Tom said, was a challenge, was one of the early cities -- Anchorage fluoridated their water supply in 1953. So really one of the knowledgeable, astute, early adopters, and it would just be a tragedy to go backwards.

MR. GRIFFITH: I should add one thing though, out of the 180 or so villages in Alaska, the number that currently fluoridates is bouncing around between only five and 10. It's not very many that fluoridate. One reason is the reason that you mentioned, it's a local decision.

The other reason is that in order to fluoridate, there's a high level of local capacity requirement that's required by the state drinking water program and there are a lot of

communities that don't meet those requirements. So they wouldn't be allowed to fluoridate if they wanted to. Once they're allowed to, it's still a local decision whether they do or not.

I don't have the breakdown on those that are allowed to and are not currently, but that's another factor for a lot of the smaller communities.

MR. HENNESSY: Thanks, Bill. So to summarize these findings, I'd say that in-home water service is definitely linked to health in rural Alaska and quantity of water is likely the key factor.

I think that expanding access to adequate supplies of in-home water would likely improve the health status for rural Alaskans for respiratory infections, skin infections, severe bacterial infections, dental cavities, and probably other diseases that we just haven't studied at this point.

There are a few important remaining questions. We don't really have a good handle on what the healthcare costs are associated with the lack of in-home water in Alaska. We've taken a few attempts at trying to evaluate this. The difference in the rates that I've just shown you could be converted into dollar costs associated with healthcare. It just has not been done.

We also don't have a very good handle on the long-term health consequences or costs associated with the lack of in-

home water service and a good example might be the elevated rates of meningitis in rural Alaska. Bacterial meningitis has a fatality rate of about 5%. Children that survive, one in three have some kind of neurologic deficit that becomes lifelong. They might have deafness. They might have some -- they might have some neurologic problem that becomes a lifelong hindrance to them and we don't have any idea what the impact of those are and how much that could be attributed to lack of water service.

The same with chronic lung disease in children in rural Alaska, we have the highest rates of hospitalization for pneumonia in the United States. There's repeated respiratory infections. Some of those children end up with chronic lung disease and they end up dying at a much earlier age, and poor dentition certainly has a long-term consequence, not only from a health standpoint, but perhaps from an employability standpoint and the long-term success of that individual in society. So those are a few of the unmeasured elements that we don't really have a handle on.

I do want to mention briefly that this issue of water and sanitation service delivery is one of the 25 leading health indicators that is being tracked in Healthy Alaskans 2020. It's indicator 19 and it's -- Bill's going to get into this more, but as -- we are tracking and then put this right up to the top as one of the key factors that we're looking at.

I just wanted to acknowledge my many colleagues who helped put all this information together that I could share with you today. So thank you.

MS. ERICKSON: Let me -- yeah (affirmative), let me switch over and do you want to see if folks have additional questions while I (indiscernible - too far from microphone).

CHAIR HURLBURT: Sure. Any other questions?

COMMISSIONER YEAGER: This is Susan. I have a question. What effort is really being made now to get that water into those villages, you know, up and out in the Bethel area? I was just over there a week ago, went up the river for three villages and I think two of them didn't have running water. They had just the big buckets. Is there some active plan going on to bring water?

MR. HENNESSY: That's a great segue question to Bill Griffith's presentation and we're going to -- and he'll cover and Mike will get into that, too, so.....

COMMISSIONER YEAGER: Thank you (indiscernible - too far from microphone).

MR. GRIFFITH: That's why we're here. Thank you for setting that up. So my name's Bill Griffith. I work with the Alaska Department of Environmental Conservation. I work with several programs that provide funding and technical assistance to communities around the state to improve water and sewer conditions, and in particular, with the state of Alaska, we've

got the Village Safe Water program and the Remote Maintenance Worker program that helps to provide technical assistance.

We work very closely with the Alaska Native Tribal Health Consortium. Mike Black's here and he's going to cover some of this material, as well. So for about half a century now, we've focused on putting the honey bucket in the museum and keeping it there.

We've made a lot of progress. About 30 years ago, less than one in four rural Alaska households had running water and sewer. By 1996, we were over halfway there and I think a lot of people at that time felt like we were well on our way to providing running water and sewer to all the homes in rural Alaska, but today, we're still only about 75% of the way there.

Now, you'll see numbers that get us over 90%, if you include regional hubs and some of the communities along the road system, so -- but when we think -- I think traditionally about the remote Alaska communities, we're just a little over 75% of all rural homes with running water and sewer.

So we've actually done that using what we call a centralized approach. That means they have a system that's not a lot different than what you find in Anchorage or Fairbanks. We treat 100% of the water to full regulatory compliance regardless of ultimate use and that's just the rule in the United States. That comes from the Safe Drinking Water

Act and whether you're using water to flush a toilet or to drink or to wash, it's the same requirement for all the water coming into the home.

We store large quantities of water and in villages, that requires a lot of heat and a lot of energy. We distribute that treated water to individuals' homes with pipes or some kind of a covered haul vehicle and then we collect all the household sewage, typically dispose of it in a lagoon, and again, to keep that water from freezing, it takes a lot of energy.

So this slide kind of summarizes how we've gone about providing service. Most communities have pipes. About 134 rural communities have pipes, a little over half of all rural communities. About 21% have individual wells and septics. That would be an example of a decentralized system, that we're able to use in some communities, but for the most part, soils don't allow us to provide service that way.

We still have about 43 communities without running water and sewer, and then the remaining communities have what we called a covered haul system or some kind of a mixture between wells or haul and pipes. I'll talk more about the unserved communities in a little bit here.

I want to talk a little bit about the categories of what we call project needs or funding. Each year, engineers at the state of Alaska and the Alaska Native Tribal Health Consortium

put together an updated database of what the project funding needs are and we typically divide that up into three categories.

The largest piece of funding needed is what we call upgrades or replacements to address substantial health threats, and that's a little over $400 million right now. Now, I think all three of these numbers are a little low, but probably proportionately, they're not different than the way this pie looks.

When we talk about upgrades and replacements, we're talking about trying to keep existing systems running. So all those piped systems out there, a lot of them are reaching 20, 30, even 40 years old. They don't meet current regulations in some cases. There's inadequate storage or inadequate supply or maybe the lagoon's having a leak or something like that. That's that largest piece of the pie.

The next largest piece, at this point, is what we call first time service. So those are unserved homes and what would it take to hook all those homes up. This estimate of $292 million, again, is probably low, but that's the next largest piece of funding.

The last piece, this upgrades to replace -- to benefit system operation and maintenance and address minor health threats, we don't use any of our current funding for that piece, just to make systems more efficient, address minor

problems. We don't have enough money to do any of that. So that largely goes unfunded.

MR. PUCKETT: Just real quickly.....

MR. GRIFFITH: Yeah (affirmative).

MR. PUCKETT: Those are total project costs. That's not an annual cost, right?

MR. GRIFFITH: That's correct. That's simply a capital cost. That's correct. I'm just talking capital costs right now. So this slide shows funding that we have available to address those needs and we hit a high point in 2004, with over $100 million of funding coming into the state from all sources, actually, over $120 million.

It's kind of been on a steady decline since then. Now, we're about half of that, a little over $60 million coming in. I'll just mention a little bit about what's happened with the decline. Those bottom three bars are Alaska-specific funding and by that, I mean, it's essentially an earmark that comes our way by way of our congressional delegation.

The very bottom bar is state funding only that's required as a match for those other two blue bars, and that's where the real decline has come, in that federal funding that's Alaska-specific. The purple bars at the top are Indian Health Service and the EPA Tribal set-aside funds, and those come to Alaska by way of formula from a national pot of money and it's not a matter of, you know, how much clout our delegation has

in Congress and that's remained relatively stable over the years. It's that Alaska-specific funding that's declined so much.

So this graph shows kind of a combination of the last two. The bottom line is total funding from all sources that's gone down from about 120 million down to a little over 60 million, and then that top line is the need for project funds has kind of steadily increased from a little over 400 million to over $700 million.

So the gap between the money that we have available and the need for funding has grown from 300 million to over 600 million. So we're, you know, from my perspective, we're kind of losing ground here.

I'm going to turn it over to Mike to talk a little bit about some other aspects and in particular, some of the efforts going on with operation and maintenance.

MR. BLACK: Thank you, Bill. My name is Mike Black. As Bill mentioned, I work for Alaska Native Tribal Health Consortium, but previous to coming to work for them, approximately four years ago, I worked for the state of Alaska for 30 years and that was with the Department of Community Regional Affairs and after that, Department of Commerce. Both at that time and the time I've been with Alaska Native Tribal Health, has been primarily dealing with rural community issues and this is one of them.

Sanitation has been a subject that I've been involved in for quite some time. Currently, I'm the Director for the Rural Utility Management Services of the Alaska Native Tribal Health and what that is, is basically working with communities on the provisions of sanitation and other services related to healthcare.

Sanitation is a very challenging service for rural communities to provide, even after the systems are built, and in this slide, what you see is some of the reasons for that challenge. The bar charts are representing the costs of operating water and sewer in relation to percentages of household incomes. Okay, what is the purpose of that, is it basically -- rural sanitation is expensive, even after the system is built. The provision of the operating and the maintenance, what maintenance is provided, that is, by the community, is a challenge for the households, because they pay for all of the operating costs out of their incomes.

Unlike many other utilities in rural Alaska, for example, electricity, which is, in fact, supported through the state of Alaska's Power Cost Equalization Program, water and sewer doesn't have that sort of support. So most of the costs of operating the systems will be coming out of the incomes, and as we all know, households in rural Alaska don't have nearly the same level of incomes as you might see in Fairbanks or Anchorage or any of the economically more viable regions of

the state. So that's part of the challenge.

Let's look at where money is spent. Advance the slide there for me, Bill. This is where the money is spent to operate water and sewer. As you can see, a very large portion of that is going to deal with energy. Why is that? Well, we're talking about cold climates.

In most cases, to keep water flowing, you have to keep it above 32 degrees. So that requires energy. It also requires energy in the form of pumping water from one place to another and pumping, of course, the sanitation depends on moving sewage to a lagoon site or some other treatment facility.

So all of this, when it's 30 below zero, can be very costly. In addition, any time you build a centralized water and sewer service, there is a lot of technology in that system and all that is requiring some sort of energy to keep it operating.

We also see a large component in labor and that's because the various tasks that must be incorporated into the daily routine of a water plant operator, it requires effort and that, often times, can represent a large cost to any of these systems.

Again, all these costs are being -- or most all of these costs are being shouldered by the customers that are getting the service. So these are critical issues.

So here's what we get for a bottom line. They're

expensive, no matter how they are gotten and in many cases, piped water and sewer can be less expensive than, in fact, the haul systems, because the haul systems require a great deal of labor.

Many of these communities find it a challenge, if they can afford it at all. So consequently, one of the real challenges once you get a system is making sure that the households continue to get service. The problem is if you're going to depend on household fees to keep it going, you can't allow households to continue to get service if it's not paying, right? There's a dilemma.

So if a large number of households say, "We simply can't afford this service anymore," we're back to the honey bucket. That's a real problem. So we have to address this issue and we have to either do everything we can continually to make it more affordable or to improve the customers' understanding of the need to pay, and of course, what would be ideal is if we could help their household incomes through some economic opportunities that would allow them to pay.

Available funding is certainly not adequate to meet the unmet need that Bill mentioned, the need for new systems, but adequate funding is not currently even being provided for the operation and maintenance of systems, because many of these systems are getting older and as they get older, they require more attention.

The incomes are not improving in many of these rural communities. So consequently, you're getting unfunded maintenance, which is -- can result in premature failures of the systems and every year that we can prolong these systems in place, avoids a tremendous capital investment that would have to either occur or we would lose service to that community. That's the point.

What do we need? Well, this is the bottom point here, innovation. We definitely need innovation, not only in the ways that we operate the systems and how we can save money, how we can help the customer meet the burdens of paying for the water and sewer service, but also, we need innovations in new ways of providing household sanitation.

Maybe the remaining unmet needs -- communities, in many cases, are not likely candidates for pipes because they simply are not in a location or they're in an environment where pipes would be extremely expensive to operate. They're either extremely small or in a challenging situation. So we're going to have to look at other solutions, besides just the pipe solution, the centralized approach, if you will.

Here are some programs that underwrite the operation and have -- well, actually, the construction, as well as the operation and maintenance of the systems that are currently in place. These are important programs for keeping sanitation provided to rural Alaska and let's look at the top and

certainly, the funding for construction, which includes primarily two partners, the state of Alaska, Village Safe Water, federal partner, Alaska Native Tribal Health Consortium, which has taken the role of the Indian Health Service, as you know.

So those are the two primary agencies responsible for actually building systems, and of course, there are many funding agencies behind us providing funding for that construction, USDA, EPA, Alaska State Legislature, of course, and others.

Operation and maintenance training, and this is where the communities -- the programs the communities can rely upon to help them with the challenge of operating water and sewer. The Remote Maintenance Worker Program is a program that with federal funding, the state of Alaska provides individuals in the regions who can help the communities with the maintenance in water and sewer, and they often travel around the communities providing advice, as well as hands-on training.

We have a program in the Alaska Native Tribal Health Consortium that also assists in that regard and that's Tribal Utility Support. So they have a similar role. Our individuals are not necessarily located in the regions, but represent probably more specialized training, such as -- or specialized expertise. We have electricians, plumbers, and all, again, specialists that help support the remote

maintenance workers who are actually working up in the regions.

Both of these programs are relatively small in relation to the challenge, I can tell you. We also have operator training. As you know, it's a federal law that you should have certified operators and actually, the state of Alaska has the lowest level of certification of any state in the union, and why is that, because first of all, they're very remote locations and the operators that we, that is, the community hires, only have enough money to work for a few hours a day. It's not a full-time job. They can't be -- because the communities simply don't have the money to keep somebody employed eight hours a day, so we've, on average, have an operator working in these rural communities, often times, one to two hours a day.

Well, that's not enough income to keep him interested in having to put up with what is often a very difficult job, as you can imagine. At 30 below, do you want to walk outside and start dealing with trying to unfreeze a frozen waterline. So the turnover is incredibly high and the ability to train operators and certify them is an extreme challenge as well.

Most of the individuals in these jobs are high school graduates and they're being expected, in many cases, to learn chemistry, math, other things, and demonstrate that in a test that would then certify them as operators. Well, our lack of

success is common and even skills training is difficult to provide them. So we have a problem there.

We do try to provide, and we are currently providing, training opportunities when available, but again, it's probably not enough to overcome just the natural economics of that job, to tell you the truth.

Utility management assistance is being provided currently with federal and state help through the Department of Commerce through Rural Utility Business Advisor program and that is a program that tries to deal with the other issue. The operator has certain challenges, but the business office, whether it's the tribal or city office that runs the utility, has its own set of problems. So that's a program that tries to help them. Again, that relies on federal funding and a lot of times, that's a declining funding base for that program.

Now, finally, on that last bullet, this is a program that my department is responsible for. It's called ARUC, and that's Alaska Rural Utility Collaborative. We, actually, provide building assistance, as well as engineering and O&M assistance to 28 communities.

Now, we run the systems in those 28 communities. What's the difference between that and these other programs, is that we actually are responsible for the day-to-day decisions in those 28. What does that do for us? It gives us a real live experience about running water and sewer in the Arctic. There

are so many challenges, that I could talk forever and I'm sure you would love that, but I'm not -- so anyway, that's another program that we have learned quite a bit from what their experiences are.

Okay, so I want to talk about one program we have at ANTHC that is trying to address the cost of operations. What we've discovered, and I've got some booklets in the back that I'd like to share with you -- anybody who's interested, one of the things we can address about affordability is the energy component of that cost.

There are opportunities to reduce cost for operations if we can capture, for example, waste heat off the electric generation plant and put it into the water system, that's less fuel oil that those communities have to buy. If we can use renewable energy, such as biomass, to provide the heat, instead of buying fuel oil and having it barged to the community, it not only provides jobs, but it also reduces the cost of that heat in the community. So there are things we're doing.

In one community, in the case of Selawik, for example, over the last four years, three years, actually, we've been working trying to develop some of those solutions. This year, we saw a reduction of $200,000 in their operating costs based on those energy efficiency moves. So there are opportunities here, but it requires each community to be looked at

separately and then their solutions need to be developed for that particular community, because each of these are unique systems, so Bill.

MR. GRIFFITH: We're going to cover a couple -- I'm going to cover a couple more initiatives that we have currently going on to try to improve, I guess, our existing program. The Alaska Water and Sewer Challenge is a state and federally funded research and development project that's underway now.

It's been ongoing since about 2012. It's projected to last about five to seven years. The funding to date is about four million dollars. We'll need additional funding before we're done. The focus of this project is decentralized approaches, which would be household-based systems that would get a lot of water reuse technologies.

When we bring things from the community level, down to the household level, we have some opportunities that don't exist at the community level, that the regulations and the rules you're playing with are a little different. Our goal is to significantly reduce the capital and the operating costs of in-home running water and sewer in rural Alaska homes.

The point I want to make about this project is that we're not really talking about cutting edge technology. We think a lot of the kinds of technology and the components of the system that we're trying to develop are out there. They just haven't been put together in a way that we can use in rural

Alaska homes and that's what we're trying to do.

We've -- what we've got is right now a sort of a competition-based project where we'll soon be funding six different multi-disciplinary teams with folks from all over the world, really, to see what they can come up with on paper. We'll score and evaluate those six teams and then we'll narrow it down to three and we'll move forward into a pilot testing phase next year.

Another thing I want to mention is, and you may have heard that the U.S. will soon be the Chair of the Arctic Council. That's an eight-nation group that gets together and sponsors projects. The state of Alaska has proposed an international conference on safe and affordable water and sewer service to rural homes throughout the Arctic. The primary event would be a two-day international symposium to be held in Anchorage during the summer of 2016.

There's actually folks from the State Department in Alaska here this week and I'm going over this afternoon with the DEC Commissioner to talk a little bit more about this project. What I hope is that we can bring together researchers, engineers, manufacturers, vendors, and others, to discuss the challenges and solutions associated with making running water and sewer available in rural Arctic homes.

One of our hopes there is that we can just continue to keep the focus on this. I think people think, well, you know,

we're getting the job done, but as we've talked about today, there's a lot of challenges remaining and we don't want people to lose track of that.

Another initiative that we're just kicking off this year is a statewide study. We've got funding from the EPA and the state of Alaska to complete this study. We want to evaluate the remaining 30 or so villages without running water and sewer. We want to put together a list of which unserved villages it may be feasible to serve with traditional centralized systems and which might require some alternative approaches to get running water and sewer into those homes.

We haven't funded any new centralized systems now for about the last five years. We've just run up into such high costs on the capital and operating side, but we have never really taken a look at all the remaining unserved communities and think about, you know, which ones might be still most reasonable to go in and do something in a traditional way.

We will have to talk a little bit about regulatory impacts in Alaska villages and I guess we're getting into the last couple of topics, which are some outstanding issues. This comes up a lot. People ask all the time, you know, how big of an impact are existing regulations and could changes in regulations result in lower costs? The answer is yes, but it's a high mountain to climb.

We do want to continue this effort and consider revisions

to federal regs that result in higher capital and operating costs, but like I say, that -- it gets difficult to do that. People don't want to consider the idea that we would have special regulations for Alaska villages from the rest of the country, but we know that, for instance, I mentioned earlier, the Safe Drinking Water Act requires the same level of treatment for all water coming into the home, regardless of what it's used for. That's not the case throughout the world. Other countries do allow water to be delivered for different purposes and treated to different levels.

Another example of how regulations affect higher costs is the Clean Water Act and the fact that it requires a very high level of sewage treatment before waste water can be discharged, regardless of how remote that community is and how far away that discharge might occur from the community and again, that's not the case throughout the world and particularly, in other Arctic nations. There's a very different approach to that.

So we're interested in talking to other nations and trying to take a look at how health risks might be affected with changes in regulations, and in fact, it -- you know, it's not a simple result. We might find that being able to bring water and sewer into homes would benefit some people -- would benefit people in some ways, some of the ways that Tom talked about, but changing the regulations to make that easier, could

have an impact elsewhere.

I mean, we might be discharging wastewater that's not treated as much or like I say, we might be bringing water into the home that's not all treated the same. So it's not an easy thing to do and there's a lot of resistance to changing federal regs, as everybody knows. Mike, this one's yours.

MR. BLACK: Okay, so as I was saying earlier, most of these costs for operating the systems, and some of them can be extraordinary, depending on the type of system and where the community is located. Obviously, the system cost increases the further north you go and just ask the North Slope Borough, because they have experienced on their budget, the enormous cost of running the systems in their communities, but all of your above the Arctic Circle, and certainly in Western Alaska, where we have very difficult conditions and high groundwater freezing conditions and water is in short supply, believe it or not. So these costs could be extraordinary.

The water and sewer utility is, in fact, the only utility in rural Alaska that does not receive any real direct support. If you were talking telephone, it gets support through the federal government. If you're talking electricity, it gets power cost equalization, but when you talk water and sewer, that is -- there is no such thing, other than the capital funding for the system itself.

So it is a complete issue at the local level. The

question is, if we keep it at the local level, will all these systems continue to provide the service they need? We're suggest, ANTHC, at least, would love to have the conversation about the need, as well as, what are our possible solutions for that, because I believe that the less we can start to look at proper maintenance of the systems and more comprehensive actions and where -- whether we can support those systems, at least, in maintaining the equipment, we may lose the benefits we've all fought to achieve.

As these systems get older, we hear all the time about catastrophic failures of one thing or another and in some cases, they resolve in direct emergency declarations. In some cases, they're just lived with, so.....

MR. GRIFFITH: That's the end of our presentation. We're ready for any questions.

MS. ERICKSON: Yes, thank you so much. So are there any questions? Yes, Susan.

COMMISSIONER YEAGER: I have a couple of questions. This one is coming to mind, in the rural areas, does the local tribal leadership, if it's a tribal entity, does that help -- does the organization and energy of those local leaders, does that have much to do with whether they have water in that community or not?

MR. BLACK: The energy and focus and priority of the tribal leaders, as well as the city leaders, when we have a

city, has everything to do with how well all services run. Water and sewer is extremely challenging. So if it's not something that is a very high priority, it often times suffers.

COMMISSIONER YEAGER: All right, what are the.....

MR. GRIFFITH: I just want to add one thing. Mike's talking about the fact that folks locally have a lot to do with how well that system runs. That, in turn, has an effect on whether improvements are funded. When we look at how we fund projects, there's two things we primarily look at. One is the health impact of the proposed project, things like whether it will provide running water and sewer for the first time or not.

The other thing we look at is how well that existing facilities are being operated and maintained, and if they're not being operated and maintained well, that is often times an obstacle to receiving new funds.

COMMISSIONER YEAGER: Just two other quick things, 1) does the Denali Commission play into any of this anymore?

MR. GRIFFITH: The short answer is no. There's no money coming from Denali Commission for water and sewer improvements at this time. For a little while, they provided some funds for washaterias and washateria renovations, but that's not available anymore.

MR. BLACK: I would like to mention there, that Denali

Commission recently announced that they would provide some resources for some energy improvements, that is, energy efficiency improvements in water and sewer. Apparently, that's going to be a new initiative, but a lot of the details, I'm not familiar with.

COMMISSIONER YEAGER: I did just hear that they now have got a restored ability to accept federal funds. So that seemed encouraging. The other, last question I was having is, has there been an approach to the congressional delegation regarding some federal support of our water and sewer systems?

MR. GRIFFITH: Well, the support we receive now is vital. We do receive the vast majority of money coming in for water and sewer improvements is federal money. We have been working closely with a delegation to try to keep the money we have coming and not to see further declines, and that's, at least, been successful over the last three or four years. We've had a pretty steady source of money without any decline.

MR. BLACK: And I'd like to say that one of the difficulties in bringing -- for operation and maintenance, at least, any federal funding, outside of grants that are available through normal sources, is that this is not a program, necessarily, that other parts of the United States would find all that, you know, as compelling, so -- but what you -- when you look at the uniqueness of rural Alaska, and both from the standpoint of lack of really any economy outside

of subsistence economy, in many places, plus the extremely challenging environment with high costs of fuel, high costs of parts and freight and so forth, it does make us in a rather unique situation, as far as keeping systems running, but it isn't something that you can expect the federal government to find a lot of support for from the other parts of the country, if you will.

CHAIR HURLBURT: Let me ask a question that's kind of a combination, philosophic and practical, and I'll give an example, and I don't -- you may have some details, I don't remember how this fits when you were in Barrow, Susan, but I remember back when the pipeline money started coming in and the North Slope Borough was pretty flush. So we're looking at putting in water and sanitation in Barrow and the (indiscernible - interference with microphone) engineers estimated with an above-ground utilidor, that it would be about $50,000 per house for that portion of Barrow, which I think didn't include (indiscernible - interference with microphone) maybe, but at the time -- but they were doing pretty good because the money was coming in and basically, they said, "We want to do it the way they do it in New York," and so they put in the underground utilidor at a cost of about $300,000 per house to bring the big diamond-jawed saws to saw in the permafrost and so on.

So I use that to ask the question, that the cost of this

can be -- always are high, can be extraordinarily high and how does it fit into the decision process where philosophically, you'd like everybody to have good clean running water, but it's kind of like healthcare overall, at some point, the realistic -- we could spend 100% of our gross domestic product on healthcare in an effort to try to keep everybody alive for another day.

How does that fit into the process of the realities that money is limited and there may be some situations in Alaska where it maybe forever would be just too darn expensive to, unless you have Bill Gates move into every village, to do that.

MR. GRIFFITH: That's really what -- that's really the story of the last 15 years or so. Back in the -- around 2000 and shortly after that, when we had a lot of money coming into the state, I don't think there was a lot of consideration about what the capital cost was. We were going to try to get it done, but as monies declined and really, as we've gotten into the more difficult to serve communities, the cost per home has really become a real focus and we've gotten to the point where we just don't know that there's any more villages that we can build systems in affordably, given the incredibly high cost of building them.

We're talking about hundreds of thousands of dollars per house at this point, and not to mention the high cost of

operation. So I think we've reached that point now with our sort of conventional approach and that's really the, again, the idea behind some more innovative approaches and see whether there isn't a much less expensive way of going about it, but given kind of the traditional centralized approach, I think we've about reached the limit of what we can in terms of hooking up homes.

MS. ERICKSON: Wes had a question.

REPRESENTATIVE KELLER: Yeah (affirmative), is DEC, or you know, has anybody looked at pulling out some cost estimates of what it would cost us if we were able to get waived from a lot of the federal regulations? I would think that, you know, changing the water standards as you suggest, so that the water that comes into the house, you know, is regulated differently, you could be talking, you know, a reduction that is just phenomenal.

Have we spent any resources at all looking at what we could do for a healthy provision of water and handling of waste if we didn't have those regs?

MR. GRIFFITH: Well, no, not at this point, and again, it's kind of a complicated equation. Any reg that you change to make it, let's say, easier to treat wastewater, probably has a potential impact somewhere else, you know, you're discharging wastewater that's treated to a lesser extent and that may, in turn, have some unintended costs and expenses.

So no, we haven't -- that hasn't happened, but we're beginning to have that conversation. I think the key would be to look at, you know, what -- where would we target our efforts and what specific regulations have the most impact on cost and where would we want to consider changes. So that's just beginning, really.

COMMISSIONER HIPPLER: Allen Hippler, Chamber of Commerce. Mr. Black, actually, you were just talking about specific regulations again and there was a question about regulations for water entering the home and then you talked about discharge. Do you have an example of a village or a small town that either has an existing sewage lagoon that is currently functional and is being told by federal or state regulators to upgrade that system, and of course, that would be very costly, or do you have an example of a village of town that does not have good treatment at all and wants to do a relatively cheap sewage lagoon and is precluded from doing that by regulations? Do you have an example for me?

MR. GRIFFITH: I'll take that one. We've got a lot of -- almost all the smaller communities in the state dispose of their wastewater in a sewage lagoon. Most of those sewage lagoons, there are not regulatory concerns with. They are either what we call total retention lagoons or they're multi-cell lagoons because they're able to discharge sewage at an acceptable treatment level.

There are a handful that don't have -- that don't provide the kind of treatment that's required and probably should be upgraded. The difficulty is that we don't have the money to do so. We don't have the capital funds to do so in most cases and at this point, there's a discussion that's gone on between state -- state and federal regulators, where they're aware of that situation, but they haven't required changes to be made, simply because there's not money to do so.

Then in the case of communities that would like to improve their wastewater treatment, but haven't been able to, again, it's primarily a capital funding issue.

COMMISSIONER HIPPLER: And if I could follow up?

MR. BLACK: And I could add that maybe a better example of what you're talking about would be direct ocean outfall, where many of the communities in the past, the coastal communities are relatively small, have been allowed to discharge directly into the ocean, and in fact, that no longer is possible. Is that right, Bill? So.....

MR. GRIFFITH: Well, it's not permitted, but again, there's two issues here. One is what the regulations require and the other is what capital funding allows us to do and we certainly don't have -- we certainly can't do everything that's required with the capital funds we have available.

COMMISSIONER HIPPLER: So the implication is that there is a village or villages that right now are under threat of

being held in violation of various DEC standards or being compelled to improve their wastewater disposal system in a cost effective manner and it's just not being enforced right now?

MR. GRIFFITH: I think that's accurate, because again, that -- the threat is there, but there's also an awareness that the capital funds are not available and in many cases, the operating funds wouldn't be there to allow that community to come into full compliance.

COMMISSIONER URATA: How many people are we talking about that this affects? Do you have an estimate or a number? You said 20% of the communities don't have this. How many people is that?

MR. GRIFFITH: Are you talking about people who live homes without running water and sewer?

COMMISSIONER URATA: Yeah (affirmative), how many people does that account for?

MR. GRIFFITH: That's -- I mean, approximately 15,000 people, that's a rough number off the top of my head.

MR. HENNESSY: And I would add that there's some communities that are working under a covered haul system that Bill mentioned, where their water service still results in water quantity use and the two-gallon per day range. Those systems are typically able to allow them to have a flush toilet, but they're still in a situation where they're water-

rationing and those communities still suffer from the same infectious disease threats that we talked about, those water-washed diseases because of the restriction on hygiene through water rationing.

So I think I would probably increase that estimate by another proportion. Bill may know the number, but it's in the probably 15,000 to 20,000 range.

COMMISSIONER URATA: So it may be 30,000?

MR. GRIFFITH: Thirty might be a little high, but 20,000, yeah (affirmative).

CHAIR HURLBURT: The -- you mentioned these folks that -- one to two gallons a day, way less than a refugee camp recommendation, and for health, recommending 25, it seems like I recall from my MPH days, which were four years ago now, that Americans used 50 to 55 gallons, but my understanding is we use way more than that now. Is that correct, to put some context around your other numbers?

MR. GRIFFITH: Well, that's correct and it does vary regionally. I mean, obviously, people in Alaska aren't watering their lawns in the wintertime and things like that. So yeah (affirmative), but even 60 gallons per person per day is not too far off today.

CHAIR HURLBURT: Wes.

REPRESENTATIVE KELLER: Just real quick, is there anything out there on the innovative development of like

individual household products? I would think that technology is coming along and all that kind of thing and could -- do we get -- where do you go to look for information like that?

MR. GRIFFITH: Yeah (affirmative), so that's really the focus of this Alaska Water and Sewer Challenge is to see what we can do on a household basis. There are products available now, but the difficulty is that you're going to go out there on the marketplace and you're going to find one product to, let's say, treat water that you might haul into the home from a surface water source and then you're going to find another product that you might use that's a toilet off the shelf, and then another product might look at ways to some kind of recycling process, but none of it's put together in a whole house package that would work in a rural community and we think would be something that they could keep maintained and working for a while. So that's really our focus, is to bring together some of those products that are out there in a way that might be sustainable.

REPRESENTATIVE KELLER: If I could, one quick follow-up, in that process, I would suggest that it would be valuable to, you know, set our own standards, as far as what's healthy and that -- as opposed to, you know, first, importing every standard that's out there, be it federal or not, and then do our shopping, you know. I think we ought to have the whole spectrum so we understand it.

CHAIR HURLBURT: Thank you all very much for bringing us up to date on this and thank you for what you do. We are the Health Care Commission and what you guys do impacts that a lot and most of the time, even though some of it's outrageously expensive, most of the time, a lot of bang for the buck for what we do with water and sanitation, so.....

MR. BLACK: Thank you.

CHAIR HURLBURT: Our lunch is not here yet and our breakfast was a little late, so I wonder, as far as using time, do you want to break now? When the lunch comes in, maybe -- what we usually just ask is if the Commission members could get their lunch first and then there should be lots because we don't have too many public attendees. So there's should be way plenty for everybody and at 12:30, we will have time for public questions and comment.

MR. BLACK: Dr. Hurlburt, if anybody is interested in the energy savings programs, here's some books that -- little booklets that kind of summarize what we've been able to do with sanitation systems.

CHAIR HURLBURT: Thank you.

MR. BLACK: I can get more of those if there's an interest, so.....

CHAIR HURLBURT: It looks like we're okay.

11:55:50

(Off record)

(On record)

12:33:43

MS. ERICKSON: So right now, we don't have anybody signed up for public testimony or anyone online interested in testifying, so we're going to take a little bit longer lunch. I'm going to check in, in about 10 minutes to see if we have anybody who's joined us online, who's interested in testifying at that point, but just so you, just relax and enjoy your lunch for another 10 minutes, at least.

12:34:04

(Off record)

(On record)

1:03:33

CHAIR HURLBURT: Okay, so we'll go ahead and get started here again now and the first part, we're going to receive the orientation to the program here on this campus with the VA clinic here and the JBER Hospital, Colonel Susan Bisnett, who's the Commander there at the hospital and I think you'll be very impressed. It's a very nice facility and we'll see that and see here, you're getting the material that they brought to hand out. So we'll just go ahead and start and I think, Susan, you're going to start first.

COMMISSIONER YEAGER: Okay, well, this -- thank you for -- it's a tough time of the day, after lunch, but we'll try to keep it to the point, so we don't torture anyone, but we're

grateful for this opportunity to share a little bit about what goes on in the VA, and for the active duty folks at JBER, Dr. Hurlburt introduced Colonel Bisnett, who's the new Commander, I mentioned her earlier, is our Commander of the 673rd Med Group, also is a pulmonologist and so we're very grateful to have her here and I'm just, as I mentioned earlier, she's a tremendous partner.

A lot of you know Colonel Harrell because he was on the Commission before and then, so we're having a -- we have a great relationship. It's continued with Colonel Bisnett as our joint venture partner.

So I have some slides here about the VA. I want to run through them. I'll try to go pretty quickly because then we'll be able to have, you know, give Dr. Bisnett an opportunity to talk about 673rd and our joint venture and then we'll have an opportunity, hopefully, for some folks to go on the tour to see the physical plant and how we actually deliver the care in this area. So any questions before we get started? Okay.

This just gives -- I guess this is an act of faith, isn't it, looking down here and then validating. This is just a quick look at some of the topics this slideshow covers. One of the things, you know, I think a lot of you have probably heard that -- heard about -- I guess I should ask, has anyone heard -- not heard about what happened in Phoenix, Arizona a

few months ago, electronic wait list? Bad word.

UNIDENTIFIED SPEAKER: Everybody's heard.

COMMISSIONER YEAGER: Everyone in the world knows about it. Okay, well, this -- that situation has really affected our whole entire agency of the VA and it's also going to -- it's affecting Alaska. We don't know exactly the full extent of what the whole new legislation and our new leadership in the VA really means to us up here.

We're all in the process of trying to figure that out, but we do expect big changes starting FY15, which for us, starts October 1, and so we're getting very close to that. So we're looking at some major changes on how we're funded and how we provide care in Alaska. So we'll get into that a little bit.

So just to let you know, though, that -- let me pop back one quick minute, for a sec, to let you know that our new leader is Robert McDonald. He is a veteran, Academy graduate, spent most of his career at Proctor and Gamble, overseas in Japan for quite some time, and then various jobs throughout -- in different product lines for Proctor and Gamble, and so he is now our new Secretary of the VA, which is very interesting and I'm -- I'll be very curious to see how being -- coming from more of a private sector giant organization, international organization to see how he -- what he can do to help the VA, you know, a government organization. So he's

here with us.

We also now -- during that whole changeover, we are now looking to, in the VA, for a new head of our -- a new Head Physician. Dr. Petzel had retired. Dr. Jesse retired. So those were our two top clinical leaders of the VA and they're both gone now. So the organization is in the process of finding the new clinical leadership and they have acting people in those roles.

We do know that there was a law signed on August 7th for a total of additional $16.3 billion for veterans, and it's really all about access to care and that's what the whole sort of issue, one of the issues, down in the Lower 48 was this idea of an electronic wait list, that is basically veterans waiting for care that they need and they weren't getting, which was resulting in some very negative outcomes for them.

I will say, up in Alaska, a year ago August, we had a wait list of a little over 900 veterans waiting for primary care and we then, at that point, a year ago, began our working with private sector, the community sector, Anchorage Neighborhood Health Center, Cornerstone, Capstone, many other organizations and private physician offices to see veterans for primary care, if we couldn't get them in within that two weeks.

So that was huge. We started about a year ago and as a result, we really do not have a wait list now. What our list

is now is new veterans come in and are determined to be eligible for healthcare, then we look to see, can we fit them in at one of panels under our medical home model, if not, we -- they go right out to the private sector with our relationships we have and there's plenty of capacity.

We've been very grateful for those private sector relationships to get the care to the veteran, because that's really what's important to us, is serving veterans. If we can't do it ourselves, get the care for them, and this is very new.

What's going to happen in the Lower 48, you're going to start seeing a lot of primary care going to the private sector if that VA entity cannot provide that primary care. So as you can imagine, everyone in the VA in the Lower 48 is really hurrying around, trying to hire as many people as they can, get mobile clinics, develop relationships, in order to keep those veterans in the system for primary care, because that's our medical home model and that's where the veterans -- the other care gets coordinated, whether it be behavioral health, specialty care, the different ancillaries.

We see that as our core business, is the primary medical and behavioral health. So we, in a way, in Alaska, we are different in that we were forced, in a way, to move out and find that care over a year ago, but there are certainly many other issues and that's -- that we're working on.

So that's kind of that slide, and one last thing, it's really interesting, too, that any senior executive of the VA now can be fired without due process or any sort of paid leave. So that's comforting, since I'm one. Okay, this is one thing that you guys -- yes, sir.

COMMISSIONER CAMPBELL: How much of this additional -- of the 16-some billion dollars, is that -- a lot of that expected to stay in-house or would it be spent on the clinics out -- or our relationships outside the system?

COMMISSIONER YEAGER: I think it's going to be a combination, because some of that money will be to try to hire, fill vacancies at VA medical centers across the country. There's been many vacancies, and you know, you kind of look at that and you might have an org chart that says, you know, in our case, our new org charts will say 648 FTE, full-time equivalent people. We've got 541 people actually on duty right now, but that is actually up 50 -- that's up 50 additional positions from last year. We brought in 50 new positions.

So I think the organization had gotten so low, it was hard to function, but we still have more. So you know, that's kind of an interesting idea. You have to validate all those positions and can you really recruit, because there is a scarcity of medical providers. We certainly feel it here in Alaska and so even though it's maybe a money situation, that

may not be the solution.

It certainly really hasn't been the problem if you're in Alaska in the last couple of years. It has not been financial. So I do believe a lot of that money, though, will -- it's earmarked to go out to buying healthcare in the private sector.

So this slide, yeah (affirmative), this is just -- I'll just go quickly, is most of the people, you know, you get -- it's kind of a joke in the Lower 48, people come up and they see Alaska, you know, the small state down off of Baja and we want to assure that we're way bigger than -- two-and-a-half times Texas and so we're a very large state with, of course, you guys know, very few roads and its harsh weather and it's a very difficult challenge for veterans to receive healthcare in this environment that we have, and this just kind of reinforces, too, the lack of a road system and the distances in Alaska.

We do pay travels, I mentioned earlier, for many of the veterans, but many of the veterans are entitled to care, eligible for care, but not travel. So that becomes a big dilemma, too. How do we get the care they're eligible for without being able to pay their way here or to Fairbanks or a larger site, especially in the communities where it's a subsistence economy, there just isn't that kind of money to be using on airplane tickets, et cetera.

So some of our solutions, in terms of tele-medicine, tele and visiting providers and partnering with the tribal system helps us to get that care close to home for the veterans to kind of obviate that need to travel. So this just gives you an idea of how far, and you guys know already, but many times, other people just don't realize how far things are.

We started out and this picture and I look -- what is the network of healthcare for Alaska VA? Well, these are the clinics we have along what we -- you know, the road system. We have clinics from the -- up in Fairbanks in the Army Hospital, in the Mat-Su Clinic -- the Mat-Su Valley, we have a clinic, this facility. We have a clinic in the Kenai and one down there in Juneau, and our big partnership was a joint venture with 673rd, as our inpatient facility and main ER here in the Anchorage area, and so this shows you one version and this is part of the network of Alaska.

Then we added (indiscernible - interference with microphone). I kind of jumped, as mentioned already, our federal partners and then about two-and-a-half years ago, the VA here entered into 26 contracts with Native organizations across the state and so this is part of the care close to home.

These Native -- and we reimburse for eligible Native veterans and we pay for eligible non-Native veterans who are preauthorized to receive the care in those -- in the Native

organizations across the state, and so it's a preauthorization for non-Native veterans, unless it's an emergency, of course, and then we expect a 72-hour notification in order for us to cover those medical expenses for that veteran.

So really, our biggest campaign in Alaska is access, how to get access to care, but the most important things of that, the veteran needs to be eligible, meaning that they need to fill out a paperwork for the VA, 1010EZ form to enroll in the VA.

The vast majority of veterans, unless they're very highly service connected, we do not know about them in the VA, until after they enroll with us. It doesn't automatically go from DOD to our records as a veteran. So we are heartbroken at times when we see big medical bills of a veteran who we know would have been funded by the VA had they had filled out that paperwork, especially in highly rural areas, and that -- we see veterans that we could have paid those medivacs for them if they had enrolled in the VA, but they didn't get in until too late and then they're holding big bills or it goes without being paid.

This is -- many of you might remember Alex Spector, who was the Director here for many years, and so he put this little journey together of the VA in Alaska. It used be, not that long ago, the VA in Alaska was only a fee for service organization. All the care that the VA provided was for

purchase care, and then a tiny little clinic down there on 801 "B" Street with Dr. Parr, Dr. Patty Parr, who is retiring this week. Some of you might remember Patty Parr, and then the system's really grown since then, adding the -- this clinic just four years ago.

We had a clinic before, over by Alaska Regional, and then adding those clinics on the backbone, on the road system just over the last few years.

CHAIR HURLBURT: Susan, I keep seeing CBOC. What's that stand for?

COMMISSIONER YEAGER: Okay, I'm sorry. CB OC stands for community-based outpatient clinic. If the VA's nothing, it's known for acronyms. So please stop me, and I apologize. Yeah (affirmative), so community-based outpatient clinics are going to be a few types, one we either staff from ourselves by the VA, our property and we're leasing before we contract with an entity and they are our contracted community-based outpatient clinics.

Our sites of care, which we're very fortunate to have a beautiful physical plant, as you see in the clinic you're in right now, the Anchorage Muldoon Clinic, we'll learn a little more with Colonel Bisnett with our joint venture hospital, Joint Base Richardson, and we're connected by a corridor and you'll see that later, because we'll try to -- our goal is to get you guys through the corridor, and I don't know if you

knew, but we have a 50-bed homeless domiciliary down on Benson and "C" Street downtown that was a leased building we got from -- I think we've got it -- well, actually, we got them for a dollar or something from HUD and then we renovated it and right now, we're looking at converting 10 of those beds to substance abuse beds, and so we get veterans into our homeless domiciliary from throughout the whole state.

We also have transitional housing, too, which I don't think I have a slide for, but we have two buildings for transitional housing for veterans who are that point of -- ready for independence on a continuum of recovery, but they -- that's the last step, in a way, before they move out on their own. That's kind of a sliding scale situation.

So the other sites of care, kind of north of the range, outside of Anchorage is Fairbanks. They have a beautiful new hospital at the Bassett Army Community Hospital and we have our VA clinic embedded there and we do buy different ancillary services from them.

They're in the process of opening up a clinic out in -- a bigger military presence at Fort Greeley and so we're working on agreements so that we can -- the veterans living in that area can be seen at that Army clinic and we'd reimburse.

I mentioned the Mat-Su Clinic. That's up in the Valley. It's really a renovated office space. It's a nice little clinic. Our biggest challenge is we've been unable to find

any full-time providers out there. So that's been a very big challenge. It's an ongoing TDY's, temporary doctors, (indiscernible - interference with microphone) doctors coming and going out there.

Beginning at the end of this month, we're going to be starting a tele-primary care presence there from our providers. We have an agreement with providers at the Boise VA, and they're going to be providing primary care from Boise to -- for those -- some of those veterans if they choose to be seen via tele-primary care.

Kenai Clinic, down in Kenai, it's a nice clinic. They all have a behavioral health component. One thing I'm happy to say is that all of our vacancies for providers for behavioral health are full. In fact, we even have another physician that -- psychiatrist we're trying to get, but to keep it in the community, and that will be an over-position, but you know, you can't -- I'm really hoping to get that done for the veterans up here.

Homer Outreach Clinic, we've talked about Kenai, well, Kenai in itself, we didn't have as many veterans as we thought. For VA, a panel of patients for a team, patient (indiscernible - interference with microphone) care team, is 1,200 veterans for an MD, 900 for a nurse practitioner and so what they've done for Homer, we've leased three days' of space from the South Peninsula Hospital in Homer and our -- one of

our physicians, Dr. Brune (sp), goes down there two days a week for primary care to Homer and then our mental health nurse practitioner goes on Wednesdays, with the idea we're beginning tele-behavioral health in Homer.

CHAIR HURLBURT: So on your panel size, do you age-adjust that or is that 1,200 regardless of age? I mean, what would be some -- a ballpark, at least average age for the enrollees on the panel?

COMMISSIONER YEAGER: We don't age adjust it so much, but they do look at the panels in terms of the types of disease types, states, that people have, the complexity of the cases. So they do kind of look at that when they assign to a new panel, if they're in the Anchorage area.

If they're in an outlying area and you're the only one, then you're kind of getting whatever the patient is that, you know, that comes to you. We have a lower average age of any other VA in the country, but I think it's still around early 60's for the veterans and I'm not 100% sure of that.

CHAIR HURLBURT: So that's a pretty good size panel for that age group.

COMMISSIONER YEAGER: It is.

CHAIR HURLBURT: Yeah (affirmative).

COMMISSIONER YEAGER: It is, and that so the provider team, we call it a patient align care team, there's a provider, either an MD, a PA, well, actually, I'd say MD or

NP, nurse practitioner, because they're independent licensed. That's been the VA traditional model, but what we're doing now in Alaska, due to our difficulty in recruiting providers, is we're now expanding to include PA's, physician assistants, and so we've now just hired some new physician assistants and basically, we have, you know, a physician agreement to oversee the work of the PA's.

So it is a lot, but there is a team there. So they have the provider, you have an RN, an LPN, and then like a medial assistant, is the basic four people of a team and then you have the other folks that are assigned, like dietetics for -- that cover a couple of teams, the behavioral health folks, we have -- are trying to integrate primary care with behavior medical. So it is a big -- and it's coordination of specialty care.

So at this point in time, I'd say, there's probably not any team that actually has 1,200 patients and then we have new people. It's all -- you've got to start, everyone's new. So it takes time for them to build that panel back up the 12. The VA is talking about even going higher in the Lower 48.

CHAIR HURLBURT: I'm slowing you down, maybe.

COMMISSIONER YEAGER: It's okay.

CHAIR HURLBURT: Do you do -- if you have a provider who can maintain a panel significantly larger than that and maintain access, do you bonus them?

COMMISSIONER YEAGER: There is -- yes, in the VA, there's a -- payment for physicians is under a special Title 38 and there are -- there is a pay for performance component of the pay and so that could be an element of that pay for performance. So that is a way you could, theoretically, but it doesn't really -- there's a limit to that, so it's not -- it's kind of fenced. So I don't think it necessarily is a motivator.

The Juneau Clinic, I mentioned we have one physician and the social worker and behavioral health in the federal building down in Juneau. It's kind of one panel clinic and we also do some tele-behavioral health out of there and we're looking at some other tele-type work, tele-retinal, and tele-derm, some of the other teles that we do.

Then there's -- a lot of the veterans don't like to go through the security of the federal building and we do share over there with the Coast Guard. The Coast Guard has a clinic in that building and we have a sharing with them where our audiologist will take care of all the hearing aids in their folks. In exchange, we use their equipment for -- at no charge, no cost. It's like federal sharing.

This one's the joint venture relationship, and Colonel Bisnett, do you want me to just skip through on this one or.....

COLONEL BISNETT: No, you can speak to it a little and

I'll just pick up where you left off.

COMMISSIONER YEAGER: Okay, so very important for us, is our joint venture and there aren't that many joint ventures in the country. So this -- it's very rare to have a joint venture. Hawaii has a joint venture. Many VA's have sharing agreements with the military installations, but not really the -- more of the colocation, co-embedding, and co-construction of the DOD facility or VA facility, depending on who the host is.

So we're very lucky to have -- and ours is, up here, is kind of seen as a model of how to do it right. So we have many people that come visit us to say, "How do you guys really work this out?" So we're proud of that and it's always an evolving, changing environment. It always needs love and care, but it is very important for us, as our hospital in Anchorage and our ER, and of course, like any ER, any situation, you know, they're always triaging for complexity, and you know, looking at where the best place for veterans to go and so that's an ongoing, you know, activity.

I mentioned to some of you that the VA does manage the ICU and has the nursing staff there and the physician staff pulmonologist intensivist. Our -- and our goal is that, and this is how we practice, one standard of care. So what I really mean by that is we don't have a VA ward over here and then the Air Force, Army over there.

It's our, all our federal beneficiaries are in the facility where they need to be in the facility. So it's not different for, just because they say they are a veteran or Army or Air Force.

I mentioned that VA contributed 11 million to the construction of the building and that's kind of what goes to that joint venture and then we have the other funding sources, we call JIFs, joint incentive funds, where we can put in for grant type things to get money to activate new joint programs with each other, such as pain management, sleep studies and the other cardiology program. We do have our reimbursement mechanisms, too, for each other based on, you know, kind of what activities are going on.

Just the big picture of Alaska, this kind of facility right here is, you know, most of the veterans, of course, live in Anchorage and this is sort of our VA headquarters, so to speak, here in this facility. Overall, this year, we're looking to -- it looks like our budget, which is wrapping up, $210 million this year was our budget and I mentioned we're up to 540 (indiscernible - interference with microphone) from 496 a year-and-a-half ago, but we still have -- we need to go up higher because there's still some very serious vacancies and as you talk about a group taking care of a panel, well, you need to have all the members of the panel there or the team doesn't function and so if you're missing key people, then the

whole thing doesn't really work. So we've been pushing hard to try and get as -- get those panels up to speed, get the staff onboard.

The vet (indiscernible - interference with microphone) the state, your different numbers. Enrollees, those -- that means that's the subset of veterans who have actually enrolled in the VA. That's the subset of veterans who live in Alaska, who have filled out their paperwork and have some level of eligibility for healthcare and then, in any given year, about almost 18,000, this was for FY15 -- 14 so far, that we've actually even touched, so to speak, either directly providing care, directly buying care, providing care, or in most cases, a combination of both.

CHAIR HURLBURT: Do you have a breakdown of the clinic visits, how many are primary care visits, ballpark-wise percentage or numbers or something?

COMMISSIONER YEAGER: Well, you mean primary care compared to specialty care or.....

CHAIR HURLBURT: Yeah (affirmative). Yeah (affirmative), going to see a family medicine doctor, an internist, or.....

COMMISSIONER YEAGER: I don't really. I could get that number. We have -- I know we have about 172,000 visits here, you know, in our -- in our backbone.

CHAIR HURLBURT: Yeah (affirmative).

COMMISSIONER YEAGER: I don't really know how many we've

actually (indiscernible - interference with microphone) how many visits.

CHAIR HURLBURT: So the enrollees who are not the unique users, are people who have enrolled, but probably obtaining their medical care elsewhere because they have other kinds of coverage. So the 17,000, 18,000 would be the users, so nine or 10 encounters a year.

COMMISSIONER YEAGER: It's actually seems more like actually four or five, yeah (affirmative).

CHAIR HURLBURT: Okay, how do you get then from 17,000 or 18,000 and 172,000 encounters to four or five?

COMMISSIONER YEAGER: I don't really have that good of a breakdown for you because some veterans might have -- of that 31, they may be enrolled, but they -- we didn't see them since last year. So we might not have seen them at all this year and so we don't get the count.

CHAIR HURLBURT: The reason I'm asking, and you're emphasizing that the VA models a medical home, and in looking at -- it's the first time we've looked at it, but when we looked at the data for the state employees and retirees through the Aetna system for the first quarter of the calendar year, the encounter rate for the enrollees in that system was just very slightly over one on an annualized basis for primary care and just -- and 1.3 or something for non-primary care, which.....

COMMISSIONER YEAGER: It's lower.

CHAIR HURLBURT: .....my intuition was, my sense was that was too low and while the state's, you know, not interested in wasting money, that generally, with more primary care, you improve quality and you (indiscernible - speaking simultaneously).....

COMMISSIONER YEAGER: (Indiscernible - speaking simultaneously).....

CHAIR HURLBURT: And it's less costly because of that coordination. So this looks like, the number looks like a lot of visits, that if it was nine or 10, my intuition is that's a whole lot, unless you've got a really morbid population, which might be the case, but kind of -- but where you're model is primary care, if you're fostering that, that could represent success in managing a population in primary care to the extent that you can, if they have a lot of morbidity.

COMMISSIONER YEAGER: Yeah (affirmative), I understand what you're saying and we'd have to kind of dig down into the data. This would also, this 170,000 would also include the behavioral health visits and any specialty care visits, too, that were done in our facilities, so -- but I've been told on the average, about four visits per person.

We are seeing a little shift with the, you know, the sort of the younger guys getting out of the military now, but actually, they're very high users of the system, too, you

know, more than -- there's a lot of traumatic brain injury, TBI, many orthopedic injuries going on with these folks that have that good body gear, but they have IEDs happening. We just -- I was, actually, just a little aside, down at the -- our Seattle VA. We've got a large research program and had a presentation on traumatic brain injury and how the scientists were actually looking at the cells on the brain when the impacts occur and they're saying even one injury, one concussion injury is already, you know, starts a -- could be brain damage occurring and they could even tell us what part of the brain, lower part of the brain, and there even seems to be some people are more susceptible than other people, based on their own, I guess genetic makeup, so -- so Dr. Hurlburt, I can kind of pull one -- you know, I can't really answer your question.

CHAIR HURLBURT: Yeah (affirmative), I would suggest that maybe that includes things like PT visits.

COMMISSIONER YEAGER: It would include PT visits, audiology visits, rehab, you know, probably -- yeah (affirmative), it wouldn't be just primary care.

CHAIR HURLBURT: Thanks.

COMMISSIONER YEAGER: Yeah (affirmative). Okay, the next one is, and this kind of shows the breakdown of the veterans. We're not quite there yet. This is kind of looking at the breakdown. We have a full list of every borough in the whole

state, what the vet population is, how many veterans in that area have actually enrolled and how many are using the system and we've kind of used that as some of our target areas, targeting our activities, if we see there's a lot of veterans living in a certain borough.

I'll give you Kodiak, for example, we have a lot of veterans in Kodiak and we don't really have that many of them that are actually being seen. So the question is, why not? What's going on with those folks?

We do now have a sharing agreement with the Hana and they -- because they're seeing a lot of veterans over there now, under our Native sharing agreement, because it's really not surprising to see the number of veterans. Veterans live where the regular population -- representative of the population.

We are seeing a 5% percent growth in new veterans coming into our system this year and that's been pretty steady over the last years. In Alaska, we've been kind of steadily going up about 5%, which is under the -- what's going on in our division right now, which is Alaska, Oregon, Washington, Idaho, is our region. We're not even the leaders in the growth right now. We were -- have been in the past. That just shows you sort of the increases since 2000 -- FY02, seeing that steady increase.

This slide just shows you some of the scope of our clinical services here, that we actually provide ourselves,

hands-on, and we're primary care, both medical and behavioral health, and we also have a whole new Primary Care Program where a physician will go and visit -- we have 90 patients, actually, in that program and it's a whole team of people that support that veteran in their home and that team includes dietetics, physical therapy, the RN's, the MD, and so they -- we have a need to grow that and we do have a wait list in that program, but we've asked for a grant from the Office of Rural Health DC wise to get some funding to add a whole other team, so there's more veterans that could benefit from being able to stay at home, being supported at home so they don't -- they can avoid hospitalization.

Then the ancillary services, Homeless Veterans Program, we have a real continuum of that program I mentioned earlier (indiscernible - interference with microphone) and some of our Compensated Work Therapy Programs, our Transitional Housing. We have outreach. We have a person that his whole job is to -- - for incarcerated veterans, so if a veteran is in jail, he'll visit them to try to make sure they have -- what's their plan for when they get out of jail to try to keep them out of jail and have a plan for the -- for their, you know, the rest of their life.

Limited specialty care, you'll see a little more when we go down on our tour, we do have podiatry here, an orthopedist. We do colonoscopies, simple procedures in our outpatient

surgery here. Home Telehealth Program, we do have quite a few people who have the technology in their homes and so that tries to keep them monitored. So say if someone has COPD, well, you know, they could watch for weight changes and so whenever to change their diuretic and that to try to watch them at home. It is also security for them, too, to feel like someone's always watching what's going on with them. They have to sign in each day and we take their weight and some of their vital signs that can be recorded.

I mentioned rehabilitation with physical therapy and occupational therapy and audiology and with prosthetics, the VA, nationally, has really advanced in developing prosthetics for veterans who have injured or have suffered amputations and other physical, you know, like even strokes, other conditions. So we do have a Durable Medical Equipment Program and home oxygen that we provide. The home oxygen, we actually contract for, and I just heard recently, we had a hard time getting the oxygen out to Adak to a veteran out there. They don't like to fly those bottles.

So just a little more on the Homeless Program. I already kind of talked about some of the modalities in that program. It's really to try to have a full continuum and the VA changed in the last few years. It used to be, you know, the idea the person had to be clean and sober for 30 days before they could enter into some of our programs, but now, the VA has moved to

the housing first philosophy, get them in housing first, because how can they work on the other issues if they don't have a room over their, you know, roof over their head and water and all those things we -- many of us take so for granted. So that's been a shift in the VA in the last couple of years.

This -- I'll just point out this Grant Per Diem Program. We give them HUD-backed vouchers, actually, where we can subsidize the rent of veterans in apartments, in housing and so we have plenty of -- we have more vouchers than we can actually get veterans housing for. So we have social workers that connect with the veterans and then have to connect with the landlords to get the whole agreement that then the VA subsidizes, and that pays for that rent and kind of helps keep that veteran in the home situation, having their home.

Okay, this will be -- that's a quick one, Rural Health Program. In Alaska, of course, as you well know, we're a very rural state and healthcare's hard to get when you live off the road system, which many people do and it's expensive and difficult to travel. So I mentioned about in 2011, the Care Closer to Home, well, we do -- I mentioned that -- 26 sharing agreements we have with tribal organizations that keep people in their community and that was, you know, really grateful for the assistance of our congressional delegation in helping remove some barriers to make those things happen.

We have been -- our program is still -- we've grown from one person, actually, I was the first one when I first came back to Alaska as the Rural Health Coordinator here about three years ago, and now we have five individuals that are on staff.

We've just brought on our latest person. He's in orientation this week, actually, a West Point grad, veteran, Master's Degree. He'll be our boots on the ground, so to speak, in Fairbanks. So he'll be embedded at our clinic in -- at Bassett Army Hospital and he'll be our person there to meet with the service organizations, the veterans, to work on our relationships with the community, with -- Tananana Chiefs is really helping us out a lot on primary care, very similar mind set of medical home, Nuka model.

We're a pilot for the whole Nuka model here, one of the few VA's in the country that have that and we have some construction that will be going on next year, renovating our primary care area in the -- more similar to what you'll see at Southcentral Foundation. The design is complete and it's in the contracting process right now for construction.

CHAIR HURLBURT: So do you have a formal contract with Southcentral on doing that?

COMMISSIONER YEAGER: Yes. We have a sharing agreement.

CHAIR HURLBURT: Are there other VA facilities that have formalized that relationship with Southcentral?

COMMISSIONER YEAGER: There's just -- not with Southcentral. Well, there's a couple that they -- you mean for the Nuka training? There are a few -- two other VA's in the Lower 48, and New Jersey, believe it or not, and another one that are also pilots for Nuka, and so Southcentral has provided them all that training and does consultation with them and so there's that.

So we also -- they're going to be providing us three more sessions next month for -- we're trying to get all of our employees, because really, it's a cultural shift and the relationship between the provider and the veteran customer and so we have to have all of our people go through it. So they're going to provide us three more sessions next month and then we did get another grant called Veterans' Voices, which is the VA take on Nuka, one of the, like six in the country that got the grant. So we're really promoting that training, too.

We do, with Southcentral, have a sharing agreement, which also means that we reimburse them for any care for the eligible Native and non-Native veteran, based on the all inclusive encounter rate, which I think is about 561 right now for our outpatient visit, inclusive.

Let's see, so we're continuing to go out and reach out with the Native communities, rural communities, and really, it's about rural veterans, because in Alaska, you know, we

aren't in a situation, as you well know, where people are kind of isolated on a reservation. People living together in communities and we go there for the -- for supporting our veterans. It happens that in highly rural areas, many times, the Native health system is the only provider in town and we have agreements with -- across the state for that.

We started a program a couple of years ago called Tribal Veteran Representative Training Program. Basically, annually, we bring people to Anchorage and we have about 213, 217 people that have gone through that function as a liaison between the VA and the veteran and those health organizations in that community. So that's now why we go places because someone from our vet community will call and say, "We need the VA. We need you to come here." We've got a couple of psychologists going to St. Paul, St. John, because there have been some suicides out there recently. So we're sending our psychologists out, so -- and then when we went to Bethel, did a big stand-down a week before last.

So we went to Tuksuk Bay. We're going back for the Blackberry Festival and audiologist is going. She can do all the testing of all the veterans in that community in that clinic there. So you know, it's just really a drop in the bucket of what we really could be doing for our veterans in the rural areas. So I anticipate that program to continue to grow.

CHAIR HURLBURT: So the TVRs are community-based residents of the community?

COMMISSIONER YEAGER: Mm-hmm (affirmative), volunteers.

CHAIR HURLBURT: Is that -- I'm not sure, because we didn't have them much in Alaska, but is that kind of like the Indian Health CHR model, not the community health aides, but the CHRs?

COMMISSIONER YEAGER: Are they more of like an administrative liaison community? I'm not sure if that's.....

CHAIR HURLBURT: Yeah (affirmative), it's much more common outside Alaska in the reservation areas and we had a few up here, but not a lot, but it was a person that would help coordinate getting, whether it's healthcare needs or social service needs or whatnot.

COMMISSIONER YEAGER: Yes.

CHAIR HURLBURT: It's kind of that model in the community.

COMMISSIONER YEAGER: It is, yeah (affirmative). So we bring them in every year to Anchorage and do like a week training, VA 101, healthcare, benefits, memorial affairs. There's three large sections of VA, but for the veteran, we want to say -- they tell us what they need and we help get it to them. They shouldn't have to worry about different departments. So that's what that's about.

It used to be -- usually it would be Native veterans, but

now, since we have the sharing agreements, it's expanded to people from the village offices, and many times from the Native health organizations or other community organizations. Anyone could come to learn how to interact with the VA, connect the dots, so to speak.

I do think I mentioned a little bit -- we do have -- a couple of years, we started a tele-mental health clinic at Mr. Edgecomb in SEARHC, with SEARHC, and we're doubling that this year to get that counseling to those veterans that live in highly rural areas and they're -- this week, we're going to -- they're in Hoonah and Angoon, because we're going to reach out, through the health aide clinics. So those are our contact points. So we've been -- we're excited about that.

I mentioned a little bit on -- I won't spend too much on that, I already think I mentioned about in 2010, oncology care, the VA made a decision that oncology care for veterans in Alaska would stay in Alaska, if at all possible, rather than have these veterans sent to Seattle and then it expanded for all care that could be provided in Alaska, keep it in Alaska, and we do get monitored by a congressional report to make -- so that they can be sure that we really are keeping veterans in Alaska and not continuing to send veterans to Seattle.

Sometimes they want to go and say, if they live in Ketchikan, especially, they could be more connected. It's

easier to get down to Seattle than come up to Anchorage, airplane-wise, so sometimes they'll go because they want to.

MS. ERICKSON: Susan, did you say something about the payment schedule for these services?

COMMISSIONER YEAGER: The payment schedule for the Native sharing agreements is based on the all-inclusive encounter rate.

MS. ERICKSON: The specialty care that you're buying on the private market.

COMMISSIONER YEAGER: The specialty care -- the private market, we normally reimburse based on CPT codes for outpatient and we have an Alaska fee schedule, and the Alaska fee schedule is Medicaid plus level of reimbursement and it's based on the past experience of actual billed charges.

CHAIR HURLBURT: Medicare or Medicaid?

COMMISSIONER YEAGER: Medicaid, and so that's part of that situation of bringing in some of the preferred (indiscernible - interference with microphone) network coming and saying, "We'll pay you this amount," when they've been getting that amount from the VA, and start wondering, well, where's the incentive. So that's been one of the difficulties for us, well, you know, with this new contract we have for the preferred provider for specialty care.

We do buy some specialty care from ANTH -- ANMC, Alaska Native Medical Center, through our sharing agreement with them

and it's basically a limited basis on excess capacity, so -- and then we reimburse for -- the VA has a fee schedule to reimburse for inpatient care on the DRG basis with then, professional fees being a CPT code base for rounding, you know, and that kind of thing.

So tele-health program, just quickly, this just shows you, and you have the slides, so I won't really go over the whole thing. These are the types of tele-health we currently are delivering and then in development, we have on the right-hand side, are where we're moving towards.

We have begun more tele-primary care and we're continuing to grow that, because as we continue to encounter difficulty in recruitment of providers, the need for care continues and we're looking to other ways and that is, as I mentioned, getting -- having PA's now onboard, but also doing tele-medicine and so the last week, coming up this month, we'll be starting -- I mentioned that out of Boise VA, those providers will be supporting patients out in the Valley via tele-primary and we've been doing tele-primary here now for about a year from a provider in Denver and another provider in Florida.

Just a little bit of Alaska Federal Health Care Partnership and believe it or not, it's been going on, Dr. Hurlburt, 20 years already. It's a voluntary relationship between the VA, the Indian Health Service, ANTHC, 673rd, and the ARMY, Coast Guard, and so we have our office. It's a

joint office, jointly funded. It's -- actually, the office is over on Old Seward and we work on projects that are of mutual benefit to the federal sector.

One of the strongest things they've been doing is bringing on training classes, four different classes a year, bringing people up from the Lower 48, so that our providers can get CME and other providers can get their license or training for their licenses by bringing them together. So we've been -- the training has been -- like four sessions, we pick each, you know, each year, our planning board and then the commanders, which Colonel Bisnett and I are on that board, make a decision on what the topics should be based on the subcommittee recommendations and then we have it in Anchorage and Fairbanks.

This last session, when went around, we tested it out and we had the course in Kodiak also and we opened the course up to the private sector in Kodiak to see if that would be something that would be worthwhile for the community and it really was well accepted and we had quite a few people come from -- into Kodiak from the private sector. So we're going to try to continue that model so that when we bring these courses up -- and the private sector, community sector can participate.

Then this next slide will give you an idea of some of the other initiatives that the Alaska Federal Health Care

Partnership has been involved in. Some of you might have heard of the AFHCAN project, Alaska Federal Health Care Access Network. Well, that's actually a project -- actually was -- came out of the Alaska Federal Health Care Partnership.

So we were able to get millions from DOD and set up that network and then as it -- activation completed, ANTHC adopted it and has grown it throughout the Native clinic system around the state. So that actually started out as a partnership project. Okay, that ends the -- my slides.

CHAIR HURLBURT: So are there any of the facilities that the VA has that are subject to any state requirement or because of federal preemption, are you excluded and then you do things like radiation safety out of the central VA office or how do you handle some of those kinds of safety issues that private facilities have to do?

COMMISSIONER YEAGER: Well, of course, being federal government, we do have a tremendous amount, a number of different measures and monitors and processes and inspections. Certainly, of course, we have joint commission and we have CAP (sp), too, for lab, all the -- and CARD (sp) for behavioral health. So we have the regular -- all those accredited bodies still come to the VA also.

We do -- for the most part, are under the federal rules. There are a few situations where we do adhere to the state requirements and I think that's more in the, and I'm not an

expert on this at all, but more in the like assisted living, long-term care arena, but for the most part, we're federal.

CHAIR HURLBURT: So on like the assisted living, long-term care, you would maybe look to the state to help with the background checks they have for people that are working in that?

COMMISSIONER YEAGER: It wouldn't really be -- we do our own background checks, pretty extensive and we really don't honor other people's background checks and that takes a long time and it can be a barrier to actually getting people in place, but more of -- some of the state requirements for licensure, yeah (affirmative), is what I'm thinking about, in terms of -- we have to -- we can't just say, "We're federal. We're ignoring the state all together." No, we do have areas where we have to adhere to the state also, yeah (affirmative). Yes.

COMMISSIONER URATA: Do you have any programs or things on end-of-life care for veterans, hospices or that type of stuff?

COMMISSIONER YEAGER: We -- yes, we do have, for hospice, I think most of our hospice is contracted. We do have contracts for hospice. We do have some -- we do have about 13 or 14 contracts for nursing homes. We don't have our own VA, you know, nursing home here in Alaska.

I'm trying to think what other -- and we do have -- I

know we do have a social worker and her full job is coordinating end-of-life, and you know, the home visits. While we do pay for skilled nursing home for people to go into people's homes. We do renovate people's homes, you know, for -- modify for handicap accessibility.

So we either do that -- we do that in VHA, which is (indiscernible - interference with microphone) the healthcare part and also our benefits folks, they also do home modifications, ramps and bars and things like that. So we do have people that go into the home and do that evaluation.

COMMISSIONER STINSON: Safety?

COMMISSIONER YEAGER: Mm-hmm (affirmative). Okay.

MS. ERICKSON: I have a question. Do you have a pain management program?

COMMISSIONER YEAGER: We do have -- pain management is a huge issue for the VA. So we have a JIF for pain management. So we're working together with our partner. We're working trying to put more of that together. We do one -- nationally, what the VA is doing, is really trying to cut down opioid use, which is causing a lot of -- it's a lot of discomfort for so many veterans right now. The idea being that we need to find other ways to help veterans cope with the pain and live with pain, not just be using, you know, narcotics.

So that's been going -- that's kind of a current issue. I do get several -- quite a few complaints from veterans who

are frustrated that those, you know, those narcotics are being taken away. We do fund, you know, biofeedback and chiropractic and other methods in order to try to help people deal with chronic pain, rather than with the medication. Dr. Bisnett, is there any else on that?

COLONEL BISNETT: Yeah (affirmative). No, I would completely agree and as we -- when we go on the tour, I'll double check with my itinerary, but I'm pretty -- yeah (affirmative), pain management clinic is on the tour. So they'd be able to give you some more details about that, but it is a multi-modality program, including chiropractics. I think they even have massage therapy and acupuncture available to address all the components of pain and it has been -- I mean, it's still in a growth process, but we feel that it's a solid program and it's going to continue, yeah (affirmative).

So the way that -- when we get funding through the JIF, the Joint Incentive Fund, it's typically funding for two years and then you have to prove sustainability to be able to -- so we're kind of in that phase of the proving sustainability, but I think we will get there. It's been very promising.

COMMISSIONER STINSON: On that same topic, in September, I'll be giving a talk on opioid abuse and opioid use and abuse to the WAMI medical students and I do that every September and every April, as well as comprehensive pain management and I very strongly de-emphasize opioid use because there is the

number of case studies, the number of peer-reviewed literature that shows that opioid therapy works for chronic pain management over one year, it's really easy to sum up, it's zero.

COMMISSIONER YEAGER: Maybe we can all connect with our Dr. Joe, Chief of Staff. She's actually the -- our network, she's on the group for pain management for our Vision 20 for Alaska, Oregon, Washington, Idaho. So you know, we have a lot of veterans with lower back pain, that kind of thing that causes, you know, chronic pain.

COMMISSIONER STINSON: There's lots of way to treat it, but not opioids.

COMMISSIONER YEAGER: So I don't know if people need a little, a couple of minutes to stretch or you guys want to just press on?

CHAIR HURLBURT: I think we're okay.

COMMISSIONER YEAGER: You think we're okay, all right.

UNIDENTIFIED SPEAKER: I'm going to go to the bathroom.

COMMISSIONER YEAGER: We call that a bio-break. All right, it looks like it's more than one.

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone) two-minute break.

1:53:21

(Off record)

(On record)

2:03:57

CHAIR HURLBURT: Representative Keller had to leave.

COLONEL BISNETT: Okay, yeah (affirmative), go back one slide. Thank you. Okay, so I'd like to introduce myself again. My name is Teresa Bisnett. I'm the Commander of the 673rd Medical Group, also known as JBER Hospital, also known as the VA-DOD Joint Venture Hospital, and we are -- and I will say that we are trying to kind of change our -- we're trying to brand, change our brand within our community and to more focus, even though I did put 673rd Med Group on the top of that slide and I made this particular slide just last night. So it tells you how much to just really change your thought process to really go more toward JBER, so Joint Base Elmendorf Richardson, the JBER Hospital, to focus on joint -- that our delivery of healthcare to our joint base, as well as the DOD joint venture hospital, so to really focus on that joint term.

It's in yellow, but you might be able to see it better than myself, but we were the -- are the proud recipients of the Air Force Surgeon General's Best Hospital of the Year for 2013, and that is a -- I can say, "Thank you," but I only got here in April, so I really had nothing to do with it.

I just got -- I got just handed on a platter, a fabulous facility and continuing along the path and as we go along, I will say that, you know, we talk about how individuals are -- that you need a village to raise a child. Well, you also need

a village to keep a hospital going and you'll see what our -- I'll show you my village slide a little bit further down.

So I really welcome you all, and you know, to this conversation and, of course, to our tour that we will have, you know, following this. So I'm just going to jump to the next slide.

So this is really what we do. This is really what we are here for and really, that kind of focus is that our primary mission of military medicine is to take care of ill and injured soldiers, sailors, airmen, and Marines, and deep down in that picture there is a person and this -- when -- and this does link to the VA.

It links to the VA in terms of the ICU. So you know, of course, as an intensivist, there's going to be a little bit of ICU talk here, but when the VA was -- when the hospital was created and opened its doors in 1999, that the VA staffed the ICU, and the initial plan for that was, because we wanted to maintain continuity within that critical care area.

Critical care providers, nurses, docs, techs, are a lower density within the Air Force and so they were focused in other facilities around, you know, across the Air Force medical service and so -- but things changed on 9-11, and we, the Air Force, recognized that this -- that the ICU at the 673rd or at JBER was a prime platform for currency and also, because there was VA nursing respiratory therapy intensivists as a backbone,

that created a prime opportunity to have our critical care nurses, our internists, intensivists, cardiologists, respiratory therapists, you know, it goes on and on, to be stationed here.

So we plussed up the active duty side on the ICU and that it has become a platform for ongoing currency and our, you know, the medics that are wearing blue, the -- you know, blue, we still call this a blue uniform, but that we are frequently deployed. So our -- I think right now, we have four ICU nurses that are deployed and -- so it is a -- it has become an intensive, an ICU currency platform.

So we will go visit the ICU and you will see that it is a -- it is now a jointly staffed unit with VA leadership and so we can do this because we are a joint venture facility, that we can maintain our -- this is a currency platform and be able to deploy very capable medics.

The other piece about this slide that I'd like to mention is that this really represents almost every department in our facility, that I can tie just about every department to this slide in some way. Ones that are probably difficult, dental is probably difficult, but you know, even, you know, patient administration. Biomedical equipment and repair is key here.

Resource management, how would we be able to, you know, fund all of these things, you know, and then obviously, all of the clinical side is very clearly visible, but I just like to

show that to say that this is what we really bring to the fight.

This is a -- it is a unique platform. So this is the critical care air transport team. I don't know if you've -- if you have heard that, our C-CAT teams, that it is a unique capability that the Air Force brings to our military, to our country. This actual event was not -- hadn't -- was not related to any conflict. This was a peacetime mission, I believe, and I believe it was multi-system organ failure with pneumonia that was transferred from Kadena, or you know, either Korea or Japan and came back either, you know, went back to Hawaii or something.

So there is a network within the Pacific to have these teams available and we contribute teams to that effort, as well as teams that go down range as -- and function in the C-CAT role.

So all right, next slide. So this is our organization. So you know, we typically have a wiring diagram, just like most military organizations, and I'll just point out a few things. So we have six squadrons and a further slide kind of will highlight, a couple of more slides down, highlight all of the clinical services that we provide.

Within the, kind of that middle layer, that those are our clinical advisors. Now, I am a, you know, a physician, but we, most of our leaders -- our leadership team comes from a

vast set of experiences and so it is important to have some consultants and we call them functional advisors for particular areas and, yeah (affirmative), we have our acronyms, too.

So SGP is the Chief of Aerospace Medicine, which is currently vacant and there's another person who is kind of dual-hatted and functioning in that role. The SGN is our Chief Nurse. The SGH is our Chief of the Medical Staff, and the SGB is our Chief of Biomedical Services. So it's kind of a senior biomedical service corps. They kind of encompass a lot of the paraprofession -- I don't want to say paraprofessionals.....

COMMISSIONER STINSON: Allied Health Care.

COLONEL BISNETT: Yes, exactly, and you know, podiatry, physical therapy, includes PA's, and along that lines, and then our six squadrons and I'll go a little bit more into that, but we also have a lot of senior enlisted leadership. So a lot of our workforce are enlisted, pretty much every technician that you could think of is a very well-trained technician and so we also have leaders in those areas, as well, that help us to provide high -- the highest level of care.

All right, so the next slide is kind of an outline of our resources and I'm not going to go into that in depth, but I did want to mention, regarding our facility -- so our facility

was built in 1999. It was built to withstand a 9.2 magnitude earthquake. Thank god, we have not had to test that engineering feature.

It is -- one half of that square footage is actually in -- are in intrastitial spaces. So when you go on the tour, I'm not so sure we're going to go upstairs that would show you that, but there actually are floors between the floors, where all of the electrical, heating, air conditioning, all of the conduits of all of the services, facility services are on those floors and so that allows repair and updates and all of that to go on seamlessly without having to interfere with healthcare services.

So it is absolutely fascinating, and the, you know, the facility tour that our facility director gives is completely nonclinical and it is amazing, and you know, there's tunnels underneath and we have our own little heat plant that if all the power goes out, we can be self-sufficient and I mean, we really can be self-sufficient.

We have our own water source. We have all the heat, electricity. We could probably survive for about seven to 10 days completely closed off from the outside and so in terms of being able to respond to a disaster, such as an earthquake, that we would be able to -- I'm very confident that we would be a fully-functioning facility and that we have the backing of the supply chain of the military and so even if the -- and

we exercised this during Alaska Shield back in April, which was an amazing, amazing experience for me, 10 days after my change of command.

So it was absolutely amazing. I just got -- just pulled right into that and -- but it really was amazing at how the military interacted and collaborated with all the -- multiple, multiple civilian agencies, as well as with multiple other federal agencies to ensure that we would be able to get all of the supplies, get all of the, I'm not going to say supplies, but resources to be able to continue to provide -- to provide care.

So next slide. So our list is a little bit bigger, but the front.....

UNIDENTIFIED SPEAKER: Susan, do you know how to get (indiscernible - too far from microphone).....

UNIDENTIFIED SPEAKER: I know how to do it, but we'll put them in the dark. Is that okay?

COLONEL BISNETT: That's okay. I can be in the dark. Sometimes I feel like I am, and a couple of things that I just want to highlight to kind of link in with the VA services is our family medicine, pediatrics and internal medicine, we follow the PCMH model. So you know, it is a team approach. We have two providers, typically, on a team. Each provider's empaneled with about 1,250 patients and it is adjusted. It is adjusted for complexity. Of course, having internal medicine,

really that kind of -- we funnel out the more complex patients to internal medicine.

One other thing I -- a couple of other things I wanted to highlight is our MTBI Clinic. So that is the Minimal Traumatic Brain Injury Clinic. It is the only MTBI Clinic in the Air Force. So MTBI is something -- and that is on the tour and so I don't want to steal their thunder, but it is -- we have -- it has transitioned from being a wartime chronic kind of care, well, intermediate and chronic care for injuries sustained during combat operations, to one that is now really focused on training injuries, as well as non-duty injuries.

So we do support -- we support two brigades. One is the 425, which is a very large, and I don't know if I can tell you exactly how many people, but it's got a lot of people, in that brigade and that is an airborne brigade and they have -- they do their parachute jumps very frequently.

There are, especially in the summer months, there's a lot more because, you know, the weather is better, but they also do jumps in the winter and so every time there's a jump, and I've got a portion of another slide, there's, obviously, the potential we could have a mass casualty. Thank goodness, that does not happen very often. Those are the two things I wanted to highlight, and again, if anybody has any questions, and as we walk around, you know, I extend that, as well.

So the next slide, just being conscious of time, so

here's kind of an overview of our workload and how things have gone over the last, what, five years, and of course, this is FY13 data, and we are on track to either meet or exceed on almost every category.

So to kind of go to your question regarding the number of appointments per enrolled patients, it is a little bit -- even a little more difficult, I feel, on the DOD side because we do see a lot of patients, you know, that number of the 250, 250 K, is not just primary care and we do a lot of specialty care for non-enrolled patients.

So both the VA, we have a very robust relationship with the Coast Guard and we are a major source, not the major source, but a major source for specialty care for them and so to be able to come up with that number of encounters per patient per year, it's a little bit difficult, although it's an interesting question.

I have not seen that the AFMS has really asked to look at that and that's not a key measure and it may be that there are some mandatory appointments for active duty that then is going to skew that data. So on the sheet, on the fact sheet that I gave you, it also lists our -- some other data that I think might be important. So our enrolled population is about 37,000.

We -- our eligible beneficiaries of 166,000, that includes our -- in panels. It includes the VA across the

state because we are the inpatient facility for VA Alaska veterans, as well as the Coast Guard and so that is not just DOD numbers, and we also -- we are -- some data that I'm aware of says that we are -- we can provide some, if not all, of healthcare for 20% of the Anchorage population that are eligible, 20% of the population in the Anchorage bowl is eligible.

CHAIR HURLBURT: You would be overwhelmed if they all came.

COLONEL BISNETT: We would be overwhelmed if they all came, yes.

COMMISSIONER YEAGER: Let them in the gate.

COLONEL BISNETT: And let them in the gate, yes. Yes. Okay, so next slide. So generally, on a biannual basis, excuse me, every two years, I always get that confused. Biannual is twice a year, but every two years, we undergo -- we look at a -- do a strategic planning offsite.

So this strategic plan was from October of 2012, and so we are kind of going to ramp up to be doing our next set of strategic planning and we do that in concert with the joint base, with the air base wing, as well as with -- including in things that are felt to be important or strategic objectives for the Air Force medical service, as a whole, and then we will also follow that up with a strategic plan with the VA, so that we can be sure to tie all of our goals and objectives

together so that we're going together in the same manner or we have a, as like I've been using lately, we have a shared mental model.

So these are just some things that were felt to be important in 2012, and I'd like to highlight some of the things that really emphasize the efforts that we have made as a joint venture with the VA and so one of the things is, over on the last column, which is to implement, the facility-wide sterilization process.

So that has been a -- it has truly -- turning in to be a major success that both the -- so the sterilization process at the VA and at the 673rd, that we have merged that into a single process and we have -- we have established a new local norm for certification of sterilization for our technicians and that is a major, major step and we believe that is worthy of best practice and so we are working toward getting that recognition.

CHAIR HURLBURT: Are these DOD fostered initiatives or are they local?

COLONEL BISNETT: No, the -- these are our local -- these are our local initiatives. Like I said, so of course, in the green, I mean, these are things that are pretty much required of us as military members that, again, our mission is to support the military to provide medically ready soldiers, sailors, airmen, and Marines, as well as medically ready

medics, and that does take up a lot of our -- that takes up a lot of our time and a lot of our corporate energy, but we have to be sure that remains our primary objective, because we would not be here if that were not the case, I mean, we wouldn't exist.

Now, along those lines, of course, we want to be dual-hatted. We want to -- we want to be fiscally responsible. We want to recapture care or provide care here and like, recapture care has been kind of a mantra over the last, probably decade of -- that there had been a trend for a lot of medical care to be sent out into the network, out into the community and that, like I said, a lot of it has been to recapture, recapture, recapture, to be able to be fiscally responsible and -- but I believe, and I think it is becoming more important that we need to do that smartly and that sometimes there are things that are not necessarily -- that there are some things that we can -- that are done very efficiently out in the community and we need to take, you know, we need to take advantage of those when they're available.

So under the maximizing specialty care, the cardiology services, Ms. Yeager had mentioned that we had a -- we currently do have a joint incentive fund that is supporting primarily an outpatient cardiology practice. We do not have a cath lab and so that is something that is still ongoing, but

it is beginning to show some return on investment.

The pain clinic, we have already talked about and you guys will be able to see that and our joint venture, JV, our JVEC, our Joint Venture Executive Committee, really has oversight of all of the services that we provide jointly and we continuously are looking for new areas to expand.

All right, so next slide. This is my village slide. So it's important, as I believe that all health organizations, to maintain, to keep our patients at the center and that we -- we strive to continuously provide patient-centered care, but in order to do this, we need the assistance and the support and the advocacy of multiple, multiple different entities.

Some of these around in the cloud are entities that assist us and then there are some of them that ask us for things. So for example, you know, we've got our, you know, congressional delegations. They generally are asking us for things. They don't generally give us anything, but let's see, so like, you know, so the PACFSG, so that's the Surgeon General, the Pacific Air Force.

So we have regional commands within the Air Force, we call major commands or maj coms, and there will be a medical, a senior physician/medical -- senior medical officer that serves as a consultant to that major command and that they help to coordinate services across the entire command. So the Pacific Air Force is in the entire Pacific.

CHAIR HURLBURT: Is that based in Hawaii?

COLONEL BISNETT: It -- they are based in Hawaii, yes.

CHAIR HURLBURT: And is the physician Colonel Fredricks there (indiscernible - too far from microphone).

COLONEL BISNETT: It was, yes. Colonel Fredricks just left and he has moved on. So he has moved to AFMOA. Let's see, where's AFMOA? Right over there, right up above it. So AFMOA is the Air Force Medical Operations Agency and they provide a lot of.....

CHAIR HURLBURT: ....

COLONEL BISNETT: Yeah (affirmative), I know. Isn't that a great acronym? Yes. We have many more and they change, you know, so -- but Air Force Medical Operations Agency, their job is to help us prioritize programs, help us with developing policy and then, not only just help develop policy, but then align resources to be able to meet those policy objectives.

So they are, you know, very integral and they try and have things standardized across the entire Air Force and try -- and they also will lateralize kind of lessons learned, so that Base X doesn't have to completely relearn what Base Y figured out, you know, a year ago. So that is kind of their role and so they do -- they provide us many things and advice and leadership among them.

CHAIR HURLBURT: And that's a Pentagon position?

COLONEL BISNETT: No, actually AFMOA is in San Antonio.

So it is on Joint Base Lackland, San Antonio Lackland. So it is on the old Kelly Air Force Base, which has, you know, been BRACed and no longer exists, but physically, it's on the land that used to be Kelly, but that's now part of Lackland.

So there is another entity -- I don't think they're over there, another entity called AFMSA, which is the Air Force Medical Support Agency, and they are at the -- kind of in the D.C. area. There's not enough space in the Pentagon. So they've had to build these other things kind of around there and that's where they're located, in Falls Church, Virginia.

So we also collaborate, and again, on the joint side, collaborate where we can with Army medicine and with View (sp) Med, which is -- that's Navy medicine. We do not have much interaction with Navy medicine here in Alaska.

Sorry, so next slide. So again, you know, our partnerships are wide and varied. Ms. Yeager has already spoken of the Alaska Federal Health Care Partnership at the bottom, and of course, we've talked about the VA. Up in the top left is just to mention about the Coast Guard. So we do have a very active relationship with them.

The -- there is a patient transport that comes up here twice a week from Kodiak with about 40, generally 40 patients in each trip that we will coordinate their outpatient specialty care, as well as provide some of that specialty care.

In the center, we do have an eye surgery center for refractive eye surgery and that is a -- that is a jointly funded or kind of -- there's a lot of benefits for doing refractive eye surgery in the military because it really decreases the number of kind of DME, you know, all kinds of optics that are required for deployments that then, if you correct their vision, then they're not going to need that, so then they can't lose it and you don't have to pay for it and renewed, blah, blah, blah.

So that has a lot -- there's a lot of focus on doing that across all services and so we actually have an Army ophthalmologist, who is embedded into our -- into the facility and they do the vision corrective surgery for pretty much the state of Alaska and a lot of patients come here for that, and then the top right, that is, again, to remind me to speak about the 425, so that is inside of C17 with an Army platoon that was just about ready to jump out of it and I believe that day, there were about 15 members that had injuries because there was a very strong crosswind that day and there was -- it basically was a mini mass casualty, where I think we had 12, 15 patients come to our ER with varying degrees of trauma in about 10 minutes. So it was a pretty busy day.

Now since that time, the Army has updated and they have changed their parachute design. They have a new parachute that has a much lower failure rate and so the number of

injuries has significantly decreased and we have also improved our communication with the brigade to know exactly when they were jumping. We didn't even know there was a jump and that was part of the issue that there really was not good communication. So that has improved and our emergency room is staffed and ready every time that there is someone that's going to jump out of a perfectly good airplane. All right, and so.....

(Cell phone ringing)

UNIDENTIFIED SPEAKER: Music at the end.

COLONEL BISNETT: I guess, music at the end. Let me just see who this is. It's the Commander. Colonel Bisnett. Yes, I'll probably have to call you back, about five minutes. Okay, all right, bye. The Command Post, when the Command Post calls you, you answer the phone, so sorry about that. Then I can call them back.

So all right, so that kind of sums up my talk and I finished just two minutes over. So are there any specific questions?

CHAIR HURLBURT: Do you have any (indiscernible - too far from microphone)? Do you have any formal collaboration with ANMC now?

COLONEL BISNETT: I.....

CHAIR HURLBURT: In the past, for example, I remember times when there was a neuro surgeon at Elmendorf and he

supported both hospitals or a urologist at ANMC, and supported both hospitals in the old, you know.....

COLONEL BISNETT: Yeah (affirmative), so yes, we definitely do have collaboration with ANMC, mostly on the surgical side. The details, though, the squadron commander on surgery, he'd be able to give you a lot more details, but yes, we do and a lot of it is through the Alaska Federal Health Care Partnership, under that kind of umbrella, but there are individual -- ophthalmology is an example of shared call.

COMMISSIONER YEAGER: Nurses training.

COLONEL BISNETT: Nurses training, yeah (affirmative), yeah (affirmative), not just on the provider side, but ICU nurses going over there, our respiratory therapists going over there for kind of an expanded exposure in competency, currency. Yes.

CHAIR HURLBURT: Any other questions? Okay, thank you, both, very much. That was very interesting and I think it helped us all a lot to understand the whole healthcare sector and Alaska's piece (indiscernible - interference with microphone) parts that most people don't have -- don't know that much about, but that are an important integral part and uniquely, like Alaska, you know, really collaborating much more across all sectors like we tend to do with everything here in Alaska. So it's very helpful. So you need to make a phone call.

COLONEL BISNETT: I do.

CHAIR HURLBURT: And.....

COMMISSIONER YEAGER: And I'll get people ready to go on the tour.

COLONEL BISNETT: Yeah (affirmative), and then I'll catch up and then I'll just carry on from there.

MS. ERICKSON: Yeah (affirmative), and I had allowed a half-hour transition, but we don't have to take more than a few minutes.

COLONEL BISNETT: Well, I did -- so what I'll probably do then, because there's actually a retirement ceremony that I wanted to pop into for just a few moments back over there. So as soon as I'm done, I can come back. I don't know how long.....

COMMISSIONER YEAGER: We can meet you at the.....

COLONEL BISNETT: At the link?

COMMISSIONER YEAGER: Yeah (affirmative).

COLONEL BISNETT: Yeah (affirmative), I mean, and I'll just come back when I'm done and it should be, you know, 10, 15 minutes, and if you're not there, then I'll come and find you.

MS. ERICKSON: Are we going to do the.....

COLONEL BISNETT: The VA side first.

COMMISSIONER YEAGER: The VA first.

COLONEL BISNETT: Yeah (affirmative).

COMMISSIONER YEAGER: We'll start down in primary care and then we'll go to surgery.

COLONEL BISNETT: Okay, yeah (affirmative).

CHAIR HURLBURT: So do you want to take about a five-minute break before the tour for any biologic needs or.....

MS. ERICKSON: Yes, we can do that. We can do that. 2:33:57

(Off record)

SESSION RECESSED